)7-08965 Oswal zo Rosale s	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene	
Oswaldo Rosale	For State Deer ND, 11/23/07, DPS, Mode Certificate of Death Reg. No. 2007 395	0
Physician/ Medical Examine	KDT1 (110	
	Avery Road @ Norbeck Road Rockville Montgomery	
Funeral Director	5. Social Security Number None 1 X M 2 F 16 Yrs. last birthday) 18 Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) Months Days Hours Min. Sept. 3, 1991 Sept. 3, 1991 Foreign E1 Country Salvador	_
nd how any r	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi Maryland Montgomery Sandy Spring 1 Yes 2 XN	
the Maryland a or 28a-f show any tiffied at once. Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 E1 Salvador	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
urs afte	3 Widowed 4 Divorced or Divorced or Divorced or Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
5-0036 led within 72 hour tygiene. other than "natt the Medical Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) Student High School	
215-C be filed v mtal Hygi riked oth ent, the l	17. Father's Name (First, Middle, Last) Humberto Rosales 18. Mother's Name (First, Middle, Maiden Surname) Angelica Argueta	
212 hould b and Meni is mark	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
e, MI and 2 s fealth a item 27 traums	Humberto Rosales (Father) 17627 Norwood Road, Sandy Spring, MD 20860 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	_
Itimora ii. Pages l artment of l ortant: If	1 November E1 1 Donation 5 Other Specify. Community of the relation of Enemery of the relation of Enemery of the relation of Enemery of the relation of E1 2	r
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Physician Medical aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries Approximate Interview Between Onset an Death	
λ. /	or condition resulting in death) Due to (or as a consequence of): b.	
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be executed sician and urial - transi		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	
O. B nat the ds d by the etached i		_
Records, P.O. Box The law requires that the deatl ficate has been signed by the att page 2 should be detached for Completed by Physi	24a. Was an autopsy findings availat prior to completion of cause o	ole
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:	3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 Coatifula Rhusiana To the host of multipart and suite and suit	ty
To the Hospital within 24 hours. To the Funeral completely filled	29a. Cettine 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Agnature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) 0.C.M.E. November 20, 2007	
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State		
Registra		- 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:14PM November 23, 2007 William J. Stief /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 14608 Cutstone Way If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F Pennsylvania November 21, 1920 189-16-3100 87 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1 ☐Yes 2 ☑ No Medical Examiner must be notified Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or United States 20905 14608 Cutstone Way Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1942If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify Specify: 1945 2 Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Vice President Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be E11a Young Joseph J. Stief ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14608 Cutstone Way, Silver Spring, MD 20905 Anne M. Wheeler, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 11/26/2007 Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 ☐ Other (Specify 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Pervice U 20904 11800 New Hampshire Avenue, Silver Spring, MD Jac 23a. Part1. Enter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure—list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** CANCER OF PROSTATE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transi Exami and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performe 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) he Hospital or Attending Pi n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D09834 November 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, Maryland Barry Rosenbaum, M.D., 31. Date filed (Month, Day, Year) State NOV 2 6 2007

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

	•	For State Registrer		State of	Maryla		artme e <i>rtifica</i>				lental Hy	giene Reg. No.2	007	39501	
Physiciar /Medica Examiner		Decedent's Name (First, Min Lott Lott 4a. Facility Name (If not institute)	ie	Judy		mith	4b City	, Town, or	Location	of Death	2. Date of De Month WillM	ber 2	O, 2007 ounty of Dear	3. Time of Death	
Funeral Director		Maryland 67 5. Social Seedrity Number 217–36 –73 77	6. Se	U HOS DM 2MF	7. Age (In yr 62	s. last birthda Yrs.		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 03–16-	th ly, Year) -1945	none 9. Bin Co	thplace (State or Foreign ountry) ryland	
Maryland		Usual Residence of Decedent 10a. State 10b. Cour MD Cha	rles		10c. (City, Town or		ldorf						10d, fnside City Limits 1 ☐ Yes 2 ☑ No	
1036 Ours after death with the Maryland rail; or items 23a or 28a-f show Examiner must be notified at the Examiner must be notified at the Examiner must be notified at the Examiner must be a fine of the Examiner must	rai Direc	10e. Street and Number 133 Garner Av	enue					p Code				US			
036 urs after service	2	11. Marital Status 1 Never Married 2 Widowed 4 Divorce	}	12. Was Deced Armed Ford 1 Pes If Yes, Give Year or Da	ces? 2 ⊠ No	U.S. 13	I. Was Deci If Yes, sp 1 Tyes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white		
21215-0036 ed within 72 hours after yolene. The Madical Examine it, the Madical Examine Completed by Europeans	ompiere	15. Deced (Specify only hig Elementary/Secondary (0-12 9	est grad		4or 5+)	16a. Dec (Gin life.	edent's Usi ve kind of w DO NOT	ork done d use retired	ation during mos	st of work	ing	16b. Kind	of Business		
Maryland : Maryland : 12 should be files h and Mental Hyg Tis marked othe traumatic event,	מ	2 12010	₽W	Smith		10h M-	iling Adda	ne (Street	Lot	tie		ret	McKir		
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Mary or other traumatic event, the Mary or other traumatic event, the Mary engines.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or T Fdna M. Hall, sister 133 Garner Avenue, Waldorf, MD 2060 20a. Method of Disposition 1 8 Burial 2 © Cremation 3 © Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Loca									D 2060 20c. Local)2	Town, State			
Balti permit. Departri imports eny inju		21. Signature of Funeral Servi	R	Gro				Mt.	Harmo	ony I	ausch Fr Lane, O	wings,			
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ion of Vil noting Physicia ath. r: After this cert e funeral direct	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pen		Hospital: 1 In 28a. Date of (Month		□ ER/Outpati 28b. Time Injury		28c. Injury Work	9r: 4□ Nu	ursing Ho	h (Check only on me 5 ☐ Resin 28d. Describe	dence 6		icify)	
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Division To the Hospital or Attendit within 24 hours after death. To the Funstel Director: A completely filled in by the fundical Certification	Medica	29a. Certifier (Check only one) 2 Medic Medic 29b. Signature and title of certification (Check only one)	al Exam	rsician: To the liner: On the ba	sis of exami	nowledge, de nation and/or	investigatio	n, in my op	number	ath occurr	ed at the time,	date and place s	ace, and due	th, Day, Year)	
l (nak		30. Name and address of pers	on who c	ompleted cause	of death (It	am 23a) (Typi		land	065	38	3 Pal L	henri	20-1	2007	
State Registrar	-	31. Date filed (Month, Day, Ye	1V 2	6 2007	gistra's Sig	inature	Sp	eles	UH	VIFA		" yeur			

		4	For State	State of Maryland		artment of H		Mental H		007	39505
			Registrar		Cel	Tilicate of t	Jeam	2. Date of D	Reg. No.	001	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last					Month	Day	Year	0
	/Medic	al -	Kati Theresa Scl			4b. City, Town, or	L coation of Do		ber 20	unty of Death	
	Examin	er	4a. Facility Name (If not institution, give		_			atti			
	* 4	*	Western Maryland H			Hagersto	WII If Under 24 H	rs. 8. Date of B	urth	hingto 9. Birth	nplace (State or Foreign untry)
	Funeral Director	1	215–08–0945	M 24 F 39		Months Days	Hours M	oct	19 196		ryland
源等			Usual Residence of Decedent								
	yland		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	a-f s	to	Maryland Was	hington		lagerstow	n		r		1 ves 2 □ No
	with the	Director	10e. Street and Number 1022 Woodland W	ay		10f. Zip Code	21742		10g. Citizer	U.S.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other then "naturel", or items 23a or 28a-f show amy njury or other treumatic event, it a Medical Erain fair must be notified at angle.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No 11 Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		Race - Amer Black, White necify:	
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ary	should Mind Mind Mind Mind Mind	۲	19a. Informant's Name/Relationship (7		1	ng Address (Street					
	alth a		Victoria A. Sch	indel mother	10	22 Woodla	nd Way				
Je,	of Hermittern		20a. Method of Disposition		lace of Dispo emetery, cre	osition (Name of matory or other plac	ce)	Date		tion - City or	
Ē	Page nent c int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			en Ce m ete	~)	2-3-2007			Maryland
Baltimore,	permit. Depertmitmports any inju		21. Signature of Funeral Service Licens	Time	1	2. Name and Addre	ss of Facility	Douglas I. N. Hag	A. Fie erstow	ry Fun n Mary	eral Home Land 21742
i de			23a. Part 1. Enter the disease, or compshock, or hear/failure. List only of	lications hat caused the deat							Approximate Interval Between Onset and Death
de.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq	Ovas	cular	460	alm	-		mouth.
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		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):	cresto	11.0				00100
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Box (The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as I	N/G	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		75.4:			230	d. Date of del	
ă	d for	Physician/M	in the past 12 months? 1 🗆 Yes 2 🗓 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		□Ectopic pregnanc □ Other <i>(specify)</i> _	у			Month	Day Year
0	at the de by the	hys	9 Unknown	9□ Unknown							
٦,	es that igned b	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	underlying cause giv	ven in Part I.	23e. Di			the cause of death?
p	quire nn sig u\d b							_ 1(∐Yes 2∭∏	No 3∏Pr	robably 4 Dunknown
of Vital Records,	aw requir s been si 2 should	ompieted						24a. W	as an itopsy	24b. Were au	utopsy findings available completion of cause of
Be	The lav	E						1	rformed?	death?	2 □ No
ta		O	25. Was case referred to medical				26. Place of	Death Check on			
\geq	Physician: this certific ral director.	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 v Inpatient 2	ER/Outpatie	ent 3 DOA	ner: 4 🗌 Nursir	ng Home 5 ☐ Re	sidence 6 [Other (Spe	icify)
0	9 Ph ter th neral	E E	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	ry al	28d. Describ	e how injury	occurred	
<u>ō</u>	Attending or death.	atio	1 Natural 5 Pending 2 Accident investigation				Yes 2 □ No				
Division	il or Attending Fatter death. Director: After din by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al h building, etc. (Special	ome, farm, s fy)	treet, factory, office			n (Street and I Town, State)	Vumber or Ri	ural Route Number,
_	pours ours illection	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my known and manner stated	owledge, dea ation and/or i	th occurred at the to	me, date and popinion, death of	lace, and due to to	ne cause(s) ar e, date and p	nd manner as lace, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signalure and title of certifier	and manner stated.		29c. Licen	se number		29d. Date	signed (Mon	th, Day, Year)
	F × F O		Manyen 4	Such		1	2836		11-	29-	07.
					- 02-1/5						*
4	4-10		30. Name and address of person who	completed cause of death (Itel				ylvania A			
الب	Since At -	ato			ature		erstown	, MD 2174	+2		
43	St Regist	ate rar	31. Date filed (Mapth Day, Year) NOV 3 0 20	07 Species	9. 1	2013					

Schindel, Kati

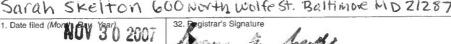
or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

WH-6

31. Date filed (Month 61) 30 2007 State Registrar

29b. Signature and title of certifier



and manner stated.

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 23, 2007

2. Date of Death Month

39507

3. Time of Death

diam's	/Medical Examiner										
		uneral irector									
2-0036	72 hours after death with the Maryland	"natural", or items 23a or 28a-f show dical Examiner must be notified at	eted by Funeral Director								

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Н	Physici /Medic		EUGENE SIEBERT SHOEMA	KER			Month NOVEMBE	Day Year	5:30 A M	
	Examin		4a. Facility Name (If not institution, give street and number NMS HEALTHCARE CENTER	r)		or Location of Deat	h	4c. County of Death WASHINGTON		
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday,) If Under 1 Yea				LING LUIN uplace (State or Foreign intry)	
и	Director		212-38-9730 ¹ X ² □ ^F	67 Yrs.	Months Day	s Hours Min.	JAN. 3	1, 1940 M	ARYLAND	
	land bw it		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
	a-f sh	ctor	MARYLAND WASHINGTON		I	HAGERSTOWN	J		1 XYes 2 □ No	
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Cou	intry?	
	s 23a		11 WEST BALTIMORE STREET,		Was Doodont of	21740	Pacifu Voc or No	U.S.		
0	or item	Funeral	Armed Force 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	11 EVEL 11 O.S. 3? ₹ No		Hispanic Origin? (S Iban, Mexican, Puer	to Rican, etc.)	Black, White		
5-0036	ural",	d by	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates		1 ☐ Yes 2 🔀 N				HITE	
5	in 72 h "natu ledica	olete	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occ e kind of work don DO NOT use retii	e durina most of wo	rking	16b. Kind of Business/li	ndustry	
2121	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4c)	r 5+)	INSPECT	OR		FURNITURE	MANUFACTUR	
nd		Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle,	Maiden Surname)		
Maryland 21	should be nd Mental marked o	은	SIEBERT JAMES SHOEMAKER 19a. Informant's Name/Relationship (Type, Print)	19b Mail	ing Address (Stre			RINE NETZ r, City or Town, State, Zi	in Code)	
	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		WAYNE E. SHOEMAKER/SON	1				RO, MARYLANI		
Baffimore,	es 1 a of Hez		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Disp		T T	Date	20c. Location - City or T		
Ĕ	. Pages tment of I tant: If its jury or of		4 ☐ Donation 5 ☐ Other (Specify)	BOONSBOE	RO CEMETI			BOONSBORO,		
Rai	permit. Pages Department of Important: If it any injury or o once.		21. Sig fature of Funeral Servi / Ligo see Paul		22. Name and Add BAST FUNE	ress of Facility ERAL HOME		d NationalF oro, Marylar		
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not er	nter the mode of d	ying, such as cardia			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	e Aro Vasc	ular	Aceia	lout	3)	Onset and Death	
	/Medical Examiner		resulting in death)	as a consequence of):		0	SCW.J		7.0	
		e.	Sequentially list conditions, if any, leading to immediate Due to (or a	as a consequence of):	Ytery	UNSea St	0		6 M	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	N'vatory	Fai	love			VW	
20,	be executed sician and burial-transit		resulting in death) Last Due to (or a	as a consequence of)						
Box 68/60	ficate I physics the t	Physician/Medical	d							
ŏ	death certificate e attending phys d for use as the	M/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome to pregnant to pre		□Ectopic pregnar	ICV.		23d. Date of deliv	/ery	
		sicia		at time of death 5	Other (specify)			Month	Day Year	
J.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions contributing to death		underlying cause g	jiven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
ecords,	w requires been sign should be	d by					1 □ Y	es 2 No 3 Pro	bably 4 Unknown	
ဝ္ပ	law re as bee 2 sho	Completed					24a. Was a	an 24b. Were aut	opsy findings available ompletion of cause of	
Vital H	sician: The law certificate has lirector, page 2 s	Som					perfor	med? death? 2 No 1 ☐ Yes	2□ No	
<u> </u>	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 To You 2 (SDN): Hospital:			Alle et al.	ath (Check only or			
ō	Phy this	<u>ان</u>	27. Manner of Death 28a. Date of I		III 3 DOA	4 JA Nursing F		ence 6 Other (Spec	ify)	
SIOL	Attending r death. ector: After by the fune	atio	2 Accident investigation	Day Year) Injury		☐Yes 2☐No				
UIVISION	F e F E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	njury - At home, farm, st etc. <i>(Specify)</i>	treet, factory, offic	е	28f. Location (S. City or Town	treet and Number or Rui n, State)	al Route Number,	
	spita ours eral fille		29a. Certifier 1 ★ Certifying Physician: To the be							
	the Hos in 24 ho he Fun pletely	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	of examination and/or in stated.	nvestigation, in m	opinion, death occ	urred at the time, o	date and place, and due	to the cause(s)	
	To To moo	Σ	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (Month		
7	42		30. Name and address of person who completed cause o	f death (Item 22a) /Time	Print)	2323		11-26-	-00 t	
	8			.126 Opal Co		gerstown,	Maryland	21742		
	Sta	to	31. Date filed (Month, Day, Year) 32. Regin	strar's Signature						

State

Registrar

NOV 2 9 2007

Sparks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician WATHAN 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SALISBURY
If Under 1 Year If Under 24 Hrs. HNCHORAR NURSING & REMAR WICOMICO Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Davs Months Hours Min. 1 XM 2 ☐ F 92 088-01-3929 Director 10/5/1915 New York Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d Inside City Limits r then "naturel", or Items 23e or 28a-f show the Medical Expinities must be notified at 1 XYes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 200 Sheffield Drive Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ¥Yes 2 ☐ No tf Yes, Give Year or Dates: 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced white Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "ne eny injury or other traumatic event, the Media. Once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 owner/operator department store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Nussbaum Louis Stelzner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1760 Governor Bridge Rd. Davidsonville, MD 21035 Diane Lee Stelzner/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Beth Israel Cemetery 11/21/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Holloway Fineral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat ASCVI) Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) isigned by the a P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 1 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 27. Manger of Death 1 Naturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred o the Hospital or Attending Pithin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funera After 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) UTIMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEISBURY 5 neer 1415 5-DIVISIUN NATESAN Vel 32. Registrar's Signature 31. Date filed (Month 103) Year 6 State Registrar

			For State	State of M	aryland / Depa	artment of H rtificate of I		, ,				
			Registrar		Ce.	Tillicate of I	Dealli	Re 2. Date of Death	g. No. 2	1117	39509	
в	Physici		Decedent's Name (First, Middle, Las IVAN	edward	SPRUNG	3		Month //	Day	Year	407 M	
	/Medic		4a. Facility Name (If not institution, give				r Location of Death		4c. County	of Death		
	Examin	ler		u Medica			Isburg		Hicomico			
	Funeral Director		5 Social Security Number 6 S	ex 7. Ag M 2□F	je (In yrs. last birthday) 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 22	Year) ,1929	Coun	ace (State or Foreign try) NEW YORK	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits	
	Maryl a-f sho ffied a	tor	MARYLAND WORCES	TER	BISHO	PVILLE					1 ☐ Yes 2 X No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V		try?	
	ath w	ra	12300 POINT VIEW			2181		7	USA	A e - Americ	an Indian	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Blac	ck, White,	etc.	
5-0036	2 hours latural		15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	pation during most of won	kina I	6b. Kind of B	usiness/Ind	lustry	
2121	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	kind of work done DO NOT use retired ECTRONICS			ΔFRO	SPACE		
2	iled v Hygie ther t		17. Father's Name (First, Middle, Last,			CIKONICS		ne (First, Middle, M	-			
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	To Be	LIONEL	SPRUNG			BEATE	RICE	RO	SENBE	RG	
ary	shot and N		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Number,	City or Town,	, State, Zip	Code)	
	1 and 2 Health a em 27 ls		ALCEA SPRUNG/WIF	E	12300	O POINT V	IEW ROAD,					
J.	ss 1 se of He item		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Demoval from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date 2	20c. Location -	- City or To	wn, State	
E	Pages nent of I ant: If ite ury or o		1 ☐ Bunal 2 Macremation 3 ☐ 4 ☐ Donatton 5 ☐ Other (Specil		CREMATOR	Y OF DELM	IARVA 11/	21/07	DELMAR	, DEI	LAWARE	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		21. Sign fure Fineral Service Lice	Hard		2. Name and Address	-	ME, SELB	YVILLE	, DE.	19975	
			23a. Parti. Enter the disease, or com- shock, or heart failure. List only	plications that cause	d the death. Do not er	iter the mode of dyli	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
	Physician	ì	Immediate Cause (Final disease or condition	a	Supsi	ŗ					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):						ť	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that initiated events	b. Due to (or as	s a consequence of):							
	uted d ansit	Examiner	Cause, Disease or injury that initiated events	C	_					- 51		
o,	e exectan an an rial-tr	Exa	resulting in death) Last	Due to (or as	s a consequence of):							
8760	cate be executed oblysician and the burial-transit	dical		d								
9	certificanding plans as t	/Mec	IF FEMALE:	23c. If yes, outcom	e of pregnancy	1.72	177		224 D	ate of delive	on.	
O. Box	atter for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 ☐ Fetal death 3	□Ectopic pregnand □ Other (specify) _	у			onth	Day Year	
P.0	that the		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	acco use con	tribute to t	ne cause of death?	
rds,	w requires that the d been signed by the should be detached	Completed by	chronic renal fail		ronary ar	try dise		1 🗆 Ye	es 2 No	3 ☐ Prob	pably 4 □Unknown	
S	law rec as bee 2 shou	lete	cardiomycrathy			,		24a. Was a		Were auto	psy findings available mpletion of cause of	
Re	The Is te ha	m o						autops perform 1□ Yes	ned?	death?		
ta	an: tifica or, p		25. Was case referred to medical				26. Place of Dea	ath Check onl on				
<u>></u>	ysicia s cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 ER/Outpatie	ent 3 DOA Ott	her: 4 \Bursing H	lome 5 ☐ Reside	ence 6 □Ot	her <i>(Speci</i> i	(y)	
0	g Ph	Ë	27. Manner of Death	28a. Date of In	jury 28b. Time lay Year) Injury		ry at	28d. Describe ho	w injury occu	rred		
<u>ö</u>	ath. r: Aft	atio	Natural 5 Pending 2 Accident investigation	n	ay / oa//		Yes 2 □ No					
Division or Vital Records,	after dez Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be building, etc. (Specify) 5 ☐ City or Town, State) 286. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 8 ☐ Could not be determined 9 ☐ Cou									
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	omple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	- WA		> Challelle	uff)3085	3	11/20	70/07		
	4.2		30. Name and address of person who		. ()	Ma Regi	inal Me	digil Cent	ter Sa	lishw	y my 21801	
r	St	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	et s						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Z U Physician George Austin Snodgrass November 21 2007 1:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Dav. Birthplace (State or Foreign
Country) Funeral Months Days Hours Min. 1 ▼ M 2 □ F 9/1/1922 Director 193-18-6843 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Merical Examiner must be notified at 1 XYes 2 No Directo Salisbury Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? 900 Booth St. 21801 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ģ filed within 72 hours a Hygiene. Specify. 3 XWidowed 4 ☐ Divorced white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sales industrial permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygis
Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Harry Snodgrass Blanche Taylor Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cooley/daughter 730 S. Park Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Susquehanna Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/07 4 ☐ Donation 5 ☐ Other (Specify) York, PA Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Ligenses Call 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably \4 | Onknown Completed 24a. Was an has certificate ha autopsy performed 20 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes '2 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063199. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yogesh Vohra M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month Day) State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Earl Wallace Sullivan 8:25 A 2007 19. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's 6. Sex 1**X** M 2□ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Director 220-16-4929 78 July 3, 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location Show 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marvland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1998 Earl Sullivan Rd. 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2□ No If Yes, Give Year or Dates: 1947–49 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iten Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 📉 No White Specify: 3 V Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Self employed Sanitation/Sewage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wellington Wallace Sullivan Virginia Ann Jett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Sullivan/ Son 845 Woodward St., Baltimore, MD 21230 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State Lakemont Cemetery 11/21/07 Davidsonville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 1/ Clab 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1□ Yes 2☑No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attendle within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Town 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arastoo Yazdani, M.D. 9400 Livingston Rd., Ft. Washington, MD 20744 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 2 1 2007

ORIGINAL

3altimore, Maryland 21215-003 1.2 should be filed within and Mental Hygiene. 1 and 2 should Department of Health a Important: If Item 27 is any injury or other trau Pages '

> **Physician** /Medical **Examiner**

Box 68760. attending physician the as esn Ö ed by the a Division or Vital Records, this ne Hospital or Attendl n 24 hours after death. ne Funeral Director: A pletely filled in by the fi

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 21, 2007 ODELL JOSEPH SHORT 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES LANHAM DOCTORS COMMUNITY HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1**∑**M 2□F DECEMBER 6, 1933 MARYLAND 214-30-0998 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Director MARYLAND PRINCE GEORGES LANDOVER HILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r UNITED STATES 20784 3927 WARNER AVENUE Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
10TH GRADE College (1-4or 5+) PRIVATE LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be JESSE SHORT EMMA JORDAN SHORT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3927 WARNER AVENUE, LANDOVER HILLS, MARYLAND 20784 GRACE LEWIS / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. CATHERINE'S CHURCH CEM.NOVEMBER 27, 2007 MC CONCHIE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Stanture of Funeral Service Ucens

LYDIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsi S disease or condition resulting in death) Due to (or as a consequence of tailure Kenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Ceregrollescul Due to (or as a consequence of): Respirator Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65909 Alenul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) asil B. alemu, mu. 8/18 Good Luck Rd., Lakham, MD. 20106 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 6 2007 Registrar Delve

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 39513

				1-For State Amend 4C, QACHD, PER FH, 12/5 Gertificate of Dea		, worke		Reg. No	2 U U	1 3931					
		/sicia	an/	Decedent's Name (First, Middle,Last)			2. Date of D			3. Time of Death					
led	ical Ex	kami		WILLIAM MICHAEL SWISHER			Month Decemi	_		0116 hrs					
				, , , , , , , , , , , , , , , , , , , ,	y, Town, or l ester	Location of I	Death	ľ	ofeely Affaet Anne Arundel	s					
	_			TOE GOOD THAT HOLD	Inder 1 Year	If Under :	24Hrs 8 Date of	Birth/MI	M/DD/YYYY) 9. Birth						
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	ryfano	28a-f show I at once,	ફ		Zip Code			10g. C	itizen of What Coun	try?					
1116	e Ma	23a or 28a-f sho notified at once.	Director		01616	•		TINT	CORP. CORP.	e.c					
-	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene.	s 23a e noti		402 CASTLE MARINA ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever i	21619 edent of His		n? (Specify Yes or		14. Race - Americ						
	eath v	item ust b	uneral		ecify Cuban	, Mexican, F	Puerto Rican, etc.)		White, etc.						
	fter d	l", or	ᄪ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	specify:			Specify: WHIT	TE .					
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	5-0036 Led within 7 Hygiene	er than Medical	Comple	2 MORTGAGE					ORTGAGE I	BANKING					
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	D 21215-00; should be filed with and Mental Hygiene	marked c event,	Be	WILLIAM MONROE SWISHER 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addr.	ress (Stree		FRANCES		City or Town, State	Zin Code)					
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	- 9 =	If item 27 ner traums		CYNTHIA ANN SWISHER/WIFE 1687 FA		netery.	Date	20	ON MARYLA c. Location - City or						
•	more Pages 1	t: If item 27 is marked other traumatic event,		1 Bunal 2 X Cremation 3 Removal from State crematory or other pla			DECEMBER		DEWENCYTT T	E WARVI AND					
	Baltimore, bermit. Pages 1 ar Department of Hea	rtant y or o		4 Donation 5 Other Specify: CHESAPEAKE C 21. Signalure of Funetal Service Licensee			2007			LE, MARYLAND					
i	Balti permit. Departn	Important: injury or oth		() FELLO	NAM FUNERA	L HOME, PA									
-	Physic			23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the modern that caused the death.	de of dying,	such as car	rdiac or respiratory	arrest,	MARYLAND shock, or heart	Approximate Interval Between Onset and					
	-/Med		y .	failure. List only one cause on each line.	failure. List only one cause on each line.										
	xam	iner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic Due to (or as a consequence of):	cardio	vascura	r disease								
				Sequentially list conditions, b.											
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	760, icate be	phys the by		IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date of delivery						
	. 68	e attending for use as	cian/	past 12 months? 1 Live birth 2 Fetal dei 4 Pregnant at time of death 5 Other (\$		Ectobic	pregnancy		Month [Day Year					
	Box 68		10	1 Yes 2 No 9 Unknown g Unknown	Specify) _			-							
	at the	≿.ન્ટ	Phy!	Part II. Other significant conditions contributing to death but not resulting in the underly	lying cause o	given in Par	t I. 23e. [oid tobac	co use contribute to	the cause of death?					
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	e law	26 2	Completed					erforme es 2		es 2 No					
	œ ⊨ — ≡	rifica or, pa	č	25. Was case referred to medical	26.Place	e of Death (Check only one)			L					
;	Vita ysteia	his ce direct	00	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA	Other ₄	Nursing Home 5	Res	sidence 6 🗸 Othe	r: Scene					
	Division of Vital Records, lator Attending Physician: The law requir is after death.	After this certificate I funeral director, page	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Inju	ry at Work?	28d. Desc	ribe how	injury occurred						
	On tendii	ector: / by the fu	ţį	X Natural 5 Pending											
	VISI or Att	Director: in by the	ij	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac		ural Route Number, City									
i	pital D		Certification:	4 Homicide determined (Specify)				vn, State	·/						
	e Hos	e Fun etely		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at	t the time, d	ate and place	ce, and due to the	cause(s) and manner as stat	ed.					
	Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	To the Funeral completely filled	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated.			onteo at the time,								
	1	\sim	Σ	29b. Signature and title of certifier	29c. Licens			- 1	9d. Date signed (Mo						
	1//	4)	my m, vovy	O.C.	IVI. E.		_	December 1, 20	·-·					
	11	VX		30. Name and address of person who completed cause of death (Item 23a)	altimora	MD 2420	01								
	7			Ling Li, MD Assistant Medical Examiner 111 Penn Street, Both Street, B	aiumore,	1717 2 12(-	-						
	В	St egis!	tate trar	31. Date filed (Md) Eday, Mar 2007 32 Jaistra's Signatu											

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4GNES **Physician** 420 M 20 2007 NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/15/1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕽 F Pennsylvania 87 208-32-3836 Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No Director Ellicott City Md. Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 USA 3712 Tustin Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🕱 No Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home the 12yrs Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linyr or other traumatic event once. Be Mary Butala John Kuklinca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan A. Green/daughter 3712 Tustin Rd. Ellicott City,Md. 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 11/21/2007 Hanover Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H.Witzke's Family F.H.Inc. 21. Signature of Funeral Services 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner seudomonas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pheuminia certificate be executed Bilateral and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the ass asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year for L Day 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No compression Fracture 24a Was an autopsy performed? (es 2 No certificate has page 2 Renal Cell Cancer 1□ Yes Division or Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28d. Describe how injury occurred funeral 27. Manner Death 28a. Date of Injury 28c. Injury at Work? Certification: After Injury (Month, Day Year) 1 Li aturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Hospital or A 24 hours after To the Hospital within 24 hours at To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 20, 2007 D0043662

Registrar
DHMH 17 Rev 1/2001

State

2

Cottoil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard

32. Registrar's Signature

College

Boyce

31. Date filed (Month, Day, Year) NOV 2 6 2007

WILLAM

State of Maryland / Department of Health and Mental Hygiene 17 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician November 23 2007 4:20 A Anne H. Spicer /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Street Harford Heart Heritage Estates If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7 Ane (In vrs last birthday) 5. Social Security Number **Funeral** 1 M 2 XF Months 26, Maryland 217 50 8742 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 17 is marked other than "natural", or items 23a or 28a-f show traumatic event, the McLical Examinations for mailified at 1 TYAS 2 TYNO **Director** White Hall Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21161 United States 3117 White Hall Rd Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Service Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel R. Harrison Anna O'Donovan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3117 White Hall Rd White Hall, MD 21161 Susan Ensor/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. Burial 2 Cremation 3 Removal from State St. John's Cemetery 11-27-2007 Ellicott City, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 0M01044 llis Þ 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Henry Fr. Ins Consostise Immediate Cause (Final 411113 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√√2 No 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel (1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV. 26, 2007 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALPHAIL KALAIL MA ZIVIY SPAMIS STA. 32. Pigistrar's Signature 31. Date filed (Month, D Day, Year) DV 26 State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25 Helen F. Silber 11 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Center for Rehab & Ext. Care Cumberland Allegany 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Director 215-50-6202 86 Dec 18, 1920 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3506 Bumble Bee Road 21520 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other thi any injury or other traumatic event; the once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Shoemaker ည Florence Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Schlosnagle/daughter 473 Spear Rd., Accident, MD 21520 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery Nov 29, 2007 Accident, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., P.O. Box 275 kemai 179 Miller St., Grantsville, MD 21536 23a. Part1. Ent. r th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h. art failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Consestive tailure Heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undenying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ advanced dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe To the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00055325 200

Registrar

State

WALSH

Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

WONSOCK SHIN

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 1439 Marvin Travis 18 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAlisla-If Under 1 Year la Regional Wicomico Conter If Under 24 Hrs. 8. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Months 1**X** M 2 □ F 402-40-6858 79 Director Kentucky 8/28/1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Maryland Wicomico Salisbury Pages 1 and 2 should be filled within 72 hours after death with the Inent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6335 Oliver Drive 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black. White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy soldier other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith F. Shown ٥ Loval H. Travis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 188, Ridgely, MD 21660 John H. Travis/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Himportant: If ite any Injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/20/07 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service / ice Holloway Funeral Home Professional Association Kest 501 Snow Hill Rd., Salisbury MD 21804 chene 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HF DAYS /Medical Due to (or as a consequence of) Examiner Ordiomy Due to (or as a consequence or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran 1 cars Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. **A** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 2□ No 1 TYes 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this
v filled in by the funeral di this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 KNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. PL.D 11/21/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swierkesz 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Taylor 20 11.70 tm Barbara Ellen 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Salisbur Wilcomico oastal HOS the Lake oiceat If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F Yrs. 219-44-1386 62 10/22/1945 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a, State 10b. County 10c. City. Town or Location 28a-f show 1 Yes 2 No Maryland Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 107 Louise Ave. 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status should be filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No white à 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys Hoffman George C. Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is any injury or other tra-Daniel J. Messick Jr/son 107 Louise Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/07 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Delleney 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NBUMON114 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE HRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed IANETES Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 Yes PAN 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24a. Was an page 2 s autopsy certificate 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1924npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 9 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medicai Certification: After Injury Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie /2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 11-20-07 2005 8416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O BOX 1733 SAVISBURY UP 2180 2 HOSFICEZ COASTAL CHALIFER WARY 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 30 PM Harold Daniel Trickett 2007 11 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital 0akland Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/25/1924 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 219-14-6755 83 Oakland, Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐Yes 2 ☐ No Directo Md Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 146 S. Church Lane 21550 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 ± Elementary/Secondary (0-12) Teacher Secondary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Daniel Trickett 7 is marked traumatic e Martha Ann West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis C. Trickett/Wife 146 S. Church Ln. Oakland, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/28/07 Omega Crematory Morgantown, Wv 22. Name and Address of Facility Stewart Funeral Home 32 S. Second Street, Oakland, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). 3 physician and as the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Maknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page Certification: To Be

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

ပိ					1□ Yes	2 2 No	1 ☐ Yes	2□ No					
Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only	one)							
2	1 Yes 2 No	Hospital: 1 Inpatient 2 □	1 Sent 1										
rtification:	27. Manner of Death 11 Avatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)											
Certific	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my known in a community: On the basis of examination and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occu	, and due to th	e cause(s) a e, date and p	nd manner as s place, and due t	tated. o the cause(s)					
2	29b. Signature and title of confifier		2	9c. License number		29d Date	signed (Month	Day Year)					

29c. License number

D23979

an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. Fourth Street Oakland, Md

29d. Date signed (Month, Day, Year)

State Registra

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29b. Signature

title of

Robert A. Goralski, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 3 0

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State

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31. Date filed (Month, Day, Year)

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2007

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery General Hospital Montgomery If Under 1 Year _ If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X F Yrs. Director 578-03-2314 93 January 7, 1914 Virginia Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location show 10d. Inside City Limits 28a-f shov notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ral", or Items 23a Examiner must b U.S.A. 15605 New Hampshire Avenue 20905 death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify. 3 Nidowed 4 Divorced ear or Dates: White 'natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. Inspector of Health and Mental Hygie f item 27 Is marked other I r other traumatic event, the other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob B. Shoemaker Maggie Alice Myers ഉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 Is any injury or other trauonce. 8411 High Ridge Road, Ellicott City, Maryland 21043 Ronald G. Wombacher - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/29/2007 4 Donation 5 Dother (Specify) Union Cemetery Burtonsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Immediate se (Final disease condition resulting in death) Onset and Death **Physician** /Medical Due to (or as consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed been: Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation (Month, Day Year) death. 1 Yes 2 No after death. 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier Date signed (Month, Day, Year) 10

Registrar
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State

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31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

6 2007

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Me	liylalid		tificate of L			eg. No.	007	395	22
	Physicia	an	1. Decedent's Name (First, Middle, Evelyn Delphey						2. Date of Dea Novembe	r 23.	2007	3. Time of De 11:10	am
	/Medic	al	4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death			unty of Death		
	Examin	er	Frederick Memo		al		Frederi			Frederick			
9	Funeral Director		5. Social Security Number 220-09-8054	. Sex 7. Age 1 □ M 2 X F	e (In yrs. las 87	st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/22/1	, Year)			
	land ow tt		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City L	_imits
	Mary a-f sho fied a	tor	MD Freder	ick	Fre	derick	:					1 M∑Yes 2	□No
	th the or 28s e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cour	ntry?	
	ath wis 23a	ral	4 Catoctin Ave		Tues in LLC	10 14	21701	ienanio Origin? (Sn			Race - Americ		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2FX If Yes, Give Year or Dates:		1	Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.	
ည် က	72 ho natur lical f	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup	ation during most of work d)	aing	16b. Kind	of Business/In	dustry	
2	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		o nor use retired Manager			Agric	cultura	l Lendi	ng
75 Q	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, L	l2 ast)				18. Mother's Nam	e (First, Middle,	Maiden Su	ırname)		
<u>a</u>	lid be lental rked o	To Be	Clarence G. De	lphey, Sr.				Nina_De	ater				
ary	shou and N s mai	-	19a. Informant's Name/Relationsh					and Number or Ru				Code)	
Σ,	and 2 lealth m 27 her tra		Leslie Wachter	(husband)				. Freder	ick, MD		tion - City or To	own. State	
Baltimore, Maryland 21215-0036	ages 1 int of H t: If Ite / or ot	170	20a. Method of Disposition XX Burial 2 ☐ Cremation				sition (Name of natory or other place	ery 11/2			-		
ij	nit. Partme artme ortan injun		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Mt.	01106	. Name and Addre	ss of Facility St	auffer I	unera	al Home		
ñ	permi Depa Impo any ii	k:));	/ tarnuline	y Daske	tty	16	521 Oposs	sumtown P	ike Fred	lericl		1702	
	Physician /Medical Examiner		231. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that daubet nly one cause or each li a. Due to (or as	or respiratory at	1m0		Approximate Interval Betwe Onset and De	en ath				
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	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseque	ence of):							
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		ledical		U							-	_	
P.O. Box	The law requires that the death certate has been signed by the attendinage 2 should be detached for use	Physician/W	IF FEMALE: 23b : Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ho 9 □ Whknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of deliv Month	rery Day Ye	ar
	quires that n signed b uld be deta		Part II. Other significant condition	ns contributing to death b	out not resul	ting in the u	nderlying cause giv	ven in Part I.		Yes 2		the cause of dea bably 4 ∐Un	
Records,	siclan: The law re certificate has bee irector, page 2 sho	Completed by	Hypertio	15:0h	_/				24a. Was auto perfo 1□ Yes		24b. Were aut prior to co death? 1 ☐ Yes	opsy findings av ompletion of cau 2 ☐ No	railable use of
or Vital		Be C	25. Was case efferred to medical examiner				- lou	26. Place of Dea	ath (Check only	ne)			
or V	Physiclan: r this certific ral director,	은	1 Yes 2 No	Hospital: 28a. Date of Inju		R/Outpatier 28b. Time o	IL 3 LI DOA		lome 5 Resi			ify)	
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Division	To the Hospital or Attending Phys within 24 hours a er dea'h. To the Funeral Director. After this completely filled 'n by the funeral dir	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place of in	jury - At hor tc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Numb	er,
	ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one) Certifyin Check only one)	Physician: To the best Examiner: On the basis of and manner	of examinat	vledge, deat ion and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)	
)	To the within To the Comp	Me	29b. Signature and title of certified	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date								7	
	8			a 300 West 9				ck, Maryl	and 2170	01	rc.		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2 7 2007 Negist	's Signat	ture &	Sporte						

State of Maryland / Department of Health and Mental Hygiene 39523 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) November 20, 2007 Physician 1:00 PM **EMMA** JEAN YAGESH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner National Lutheran Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🛛 F 62 Yrs 510-44-7069 24,1945 Kansas Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show rel', or iteme 23e or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No MDGaithersburg Director Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e nr any injury or other traumatic extra 20878 United States 12216 Morning Light Terrace Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Estee Lauder Executive Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Wehking William Schott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12216 Morning Light Terrace Gaithersburg, MD 20878 John Yagesh (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nov. 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Germantown, MD All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 20877 10 East Deer Park Dr. Gaithersburg, Md. 23a. Part1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) 540005 Physician /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year Ď in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 Unknown care nas been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 12 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26033 Ridge Rd. Damascus, MD 20872 Dr. Charles W. Karesh M.D. 31. Date liled (Month, Day, Year) NOV 2 3 32. Restrar's Signature State Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 3952	+
		¥	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	
1	Physici /Medi		June L. Adams December 8, 2007 2:00PM M	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Angele Person		Golden Crest Hampstead Carroll 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign	
30.0	Funeral		Months Days Hours Min. (Month, Day, Year) Country)	1
4	Director		216-12-7744	_
	ow ow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	
	Mary First	to	MD Carroll Westminster 1 □ Yes 🏋 □ No	
	or 28s	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	th wit 23a c 1st be	al	700 Lake Drive 21158 USA	
	r dea ems er mi	Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be not ited at	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Specify: White	
21215-0036	hour tural	d be	3 X Widowed 4 □ Divorced Year or Dates: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
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	othe vent,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
<u>la</u> r	should be f and Mental I s marked of umatic ever	To E	Oscar W. Mechalske Ella McGinnis	_
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	ľ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 and 2 Health tem 27 i		Thomas W. Collins Nephew 700 Lake Drive, Westminster, MD 21158	_
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importament of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be not ited at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Ë	t. Partmen	13	4 Donation 5 Other (Specify) Druid Ridge Cemetery 12/12/07 Pikesville, MD 21. Signature of Funeral Service Licensee	
Bal	permit. Pages 1 Department of H Important: If Ite any Injury or ot		11824 Reisterstown Road	
			23a and 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate	
	Dhysisian	4		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	_
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100	P 5	ner		
A	icate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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w.	death certifica attending plant of for use as t	/Me	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery	
Вох	atter after	ciar	23b. Was decedent pregnant in the past 12 months? 1	
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ıd	w require been sig should b		1 Yes 2 No 3 Probably 4 Unknown	1
Records,	ne law re has be ge 2 sho	plet	24a. Was an autopsy findings available prior to completion of cause of	à
<u>=</u>		Completed	performed? death? 1 Yes 2 No 1 Yes 2 No	
Vital	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Check only one)	
o	S S	은	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assistance Sec. Injury at 28d. Describe how injury occurred 28d. Describe how in	*A
	ding After fune	io	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work?	
Division	I or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,	
Ď	al or saffer	Certification:	4 ☐ Homicide determined building, etc. '(Specify) City or Town, State)	
	ospit hours unera		29a. Certifier (Check only (Ch	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	one) and manner stated.	
	Natity of Co.	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
•			Julin W. Ohn Meletry D25443 12-11-2007	
	3		30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 3. Hu W. M. Lilliam MD 68 Rolp Rd, Westminster, U D 2115)
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Registi		DEC 1 1 2007 Acres 18 April	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Azimunissa Begum DECEMBER 8. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Director 281-72-0462 1, INDIA Aug. 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show ns 23a or 28a-f shov must be notifled at 1 ☐ Yes 2☐ No Director BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Thurkill Court 21030 USA Funeral death r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife At Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mohammed Mohsin Hafizunissa Begum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moina Faruqui - Daughter 4 Thurkill Ct. Cockeysville, Md 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State **M**OBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 12-9-07 Randallstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CRITICAL AORTIC STENOSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1□ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred if or Attending Patter death. Certification: 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide To the Hospital or Atte within 24 hours after ded To the Funeral Directo completely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of clertifier 29c. License number Mehla 22 08 Decomber D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month JOGINDER P. MEHTA M. D. 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 \$2. Registrar's Signature State hours. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 8, CLONIE HELEN BOLT 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 XF 229-10-1220 92 Sept. 9, 1915 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1618 S. Tollgate Road 21015 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervising Clerk County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles (nmn) Vinson Mary Lucy Atkison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 MacBeth Ct., Bel Air, Maryland 21015 sposition (Name of Date 20c. Location - City or Town, State Betty Ann Bolt Scott / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 12-12-07 Bel Air, Maryland 21. Signature of Funeral Course License 22. Name and Address of Facility MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 114 Due to (or as a consequence of): Schimic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** bunial-transit Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natuuny or other traumatic event, the Medical

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr

Director

Funeral

Be Completed by

2

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

page 2 s certificate

Division or To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

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	Sta	t

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YGISW11 North

Bal Air Maryland

Registrar

Natural

2/ Accident

3∏ Suicide

29a. Certifier

4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 6 **Physician** 2007 10:45 a M Gery1 Bischoff /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard 5836 Barnwood Place Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year) NOV 5 1950 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🕱 F NÖV 271-44-5246 57 Ohio Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits fshow filed within 72 hours after death with the Maryla Hygiene. other than "natural", or items 23a or 28a-f shov ent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Howard Columbia MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 5836 Barnwood Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Healthcare** Insurance Risk Management h and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumetheward. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnson Gerald Link Ruth ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5836 Barnwood Place. Columbia, MD 21044 19a. Informant's Name/Relationship (Type. Print) David Bischoff - Husband 5836 Barnwood Place, Columbia, MD 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 12/7/2007 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Segret icensee H. Williams ²²Cremation Society of Maryland, Inc. Hull 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MUTASTATUL 7 months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for exits consequence of Examine be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1∐ Yes 2 No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2NO 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director After 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAS Columbia PATU Nicholus 1065

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 1 2007

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 500 PM HARLES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3ALTIMOZE SILVERTHOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours M 2□F 216-40-058 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 23a or Thorne Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Yes 2 No Yes, Give ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 Soivorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Monee. intanance s Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma Be ant's Name/Relationship (Typę. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cremation 3 Removal from State Baltimore, MI 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. e mode of dwing, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** SCVI /Medical Due to (or as a consequence of): **Examiner** YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed 1-1 YPERCHOLES PERECEMI Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 🗌 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 🗌 Yes 2) No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)50216 005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEUNETH SIBILA MA

Registrar

State

DEC 1 1 2007

31. Date filed (Month, Day, Year)

Registrar's Signature

			For State Registrar	State	of Marylar		rtmen <i>tificat</i>			and Me	ental Hy	giene Reg. Na	2007	39	529
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П	Physicia	_	Philip N. Bridg	es							Month Decemb	er 7		9:20	0 A ^M
¥.	/Medic		4a. Facility Name (If not institution		umber)		4b. City,	Town, or	Location o			4c. County of Deat			
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	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	C	rthplace (State	or Foreign
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98	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notifiled at		1 Never Married 2 Marri	ed 1 ☐ Yes !f Yes, G	2⊠ No Sive		□Yes		Specify:	,	,			White	
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•	,		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type,		5000	J J T					, 2007	
	2		Alok Mathur, M.	D., 4000	Olney I	aytons	ville	Roa	d, 01	ney,	Mary1	and	20832		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) DECEMBER 6 2007 **Physician** 6:55 A M BERLIN ETHEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE PIKESVILLE NORTH OAKS HEALTH CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 1 F 88 Director 218-12-2149 12/04/1919 MINNESOTA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE MD BALTIMORE Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21208 U.S.A. 725 MOUNT WILSON LANE APT. 426 Completed by Funeral hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No WHITE Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION the LIBRARIAN permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ROSE** DIAMOND POLLACK SAMUEL P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3600 MICHELLE WAY - BALTIMORE, MD 21208 STEVE BERLIN / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of FORBAND 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/09/2007 ROSEDALE, MD Signature o Funeral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate List only one cause in each ne. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final 5 minule **Physician** Cardiof y no you disease or condition resulting in death) /Medicai Due to (or as a consequence of): **Examiner** Atheroselumb Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hypertersion 225 certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4☐Pregnant at time of death signed by the at d be detached for 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed^a 2 No 1□ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician; 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient ို this within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

MESHULAM 31. Date filed (Month, Day, Year)
DEC 1 1 2007

29b. Signature and title of certifier

29a. Certifier

JOE/L

ST PAUL PL 01 32. Registrar's Signature

M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H Sou

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

038675

BALL

21202

29d. Date signed (Month. Day, Year)

December 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 7:25 P M 29, 2007 November BURWELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE **GEORGES** SUITLAND ENGLISH COURT 4706 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🔀 F New York 1932 Jan. 23. Director 071-28-8239 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director WASHINGTON Non-Applicable D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20020 2589 NAYLOR ROAD S.E. #202 Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TELE-COMMUNICATION SPECIALIST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH HARRIS BURWELL 2 GEORGE Α. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COURT, SUITLAND, MD. 20746 ENGLISH 4706 JONES-Daughter LISA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL Dec.07.2007 SUITLAND, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FORESTVILLE,MD. 20747 Charles E MOO981 POPE FUNERAL HOMES 5538 MARLBORO PIKE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 YEARS **Physician** BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☑ No 24a. Was an autopsy performed? Yes 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daughters Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Stother (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1x Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

the death certificate be executed and physician are the burial-t Box 68760. as attending nse P.O. the Division or Vital Records, certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

Baltimore, Maryland 21215-0036

State Registrar

(Check only one)

29b. Signature and title

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

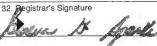
29d. Date signed (Month, Day, Year)

DECEMBER 04, 2007 D0060050

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSAIN, MD. 1221 MERCANTILE LANE, LARGO, MD. 20774 Dr. MAHRUKA

31. Date filed (Month, Day, Year) DEC 1 2007



DHMH 17 Rev 1/2001

Registrar

ECEMBER

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 10a-c, 10e-f, perF.D. 0875, 1/2 08 TT

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician ochell 2007 arolu 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore moniu 1 Year | If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1□M 2 F 2 18-30-6490 Usual Residence of Decedent 18-30-6496 1933 Mari Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Lady, Lake Lake County 1 ☐ Yes 2 No Director H11. 10g. Citizen of What Country? 10f. Zip Code 32159 10e. Street and Number 1652 Garcia Court USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify 2 3 🛣 Widowed 4 ☐ Divorced White. Completed 11:35 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 erizon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2007 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Bauhausm tasadera WD Z112Z Place of Disposition (Name of cemetery, crematory or other place) SW 20a. Method of Disposition
1 ☐ Burial 2 Cremation Date DECEMBER 3 ☐Removal from State anstrune al Chapel-Beltic 12/11 Forest HIMM 107 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Dr. Forest Hill Evens Function Chapel + Crema 21. Signature of Funeral Service Licensee MD 2/050 23a. Part1. Enter the discussion or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart fally re. List only one cause on each line. Services-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit No the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant et time of death 9☐Unknown 5 Other (specify) ed by the a detached i COCHELL 9 Unknown 23e. Did tobacco use contribute to the cause of death? ils certificate has been signed i director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CAROLYN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certification: To Division or After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending investigation 124 hours after death.

In Funeral Director: Af olderely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature end title of certifier th 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2300 4021093 RNOSTI Ne 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Bev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joann Crespo 9 2007 December 9:25 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Caroll 5. Social Security Number Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 74 Director 423-50-5803 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f sh 1 ☐ Yes 2 No Directo MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 686 St. George's Station 21136 Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EKG Technician Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julio Crespo Leona ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 686 St. George's Station, Reisterstown, MD <u> Michael Berlin - Companion</u> 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/10/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Facility Cremation Society of 299 Frederick Road, Maryland, Baltimore; 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner ng physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical within 24 one 29b. Signature 29c. License number d title of certifier 29d. Date signed (Month, Day, Year)

10 State

Registrar

30. Name and

31. Date filed (Month, Day, Year)

1 2007

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Street WESTHIUSTER MD 2115

completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12 2007 sennie Cooper 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Gilchrist Hospice Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 577-52-234 10M 20 F NC Usual Residence of Deceden 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 es 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S./ SISIS 571a Northwood Drive 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZHO Specify: Specify: 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ing Control Baltimore. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bennie Cooper Sr Bernice Faison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benita Cooper/Vaugnter Baltimore MD 2012. Date 20c. Location - City or Town, State 5712 Northwood Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Dulaney Valley 12 2. Name an Address of Facility 12/4/2007 Baltimore, Manyland 4 ☐ Donation 5 ☐ Other (Specify) Voughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York and Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MonThs ta, disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Defiknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 2 ☐ Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

items

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"natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Meany Injury or other traumatic event, the Meany Once.

the Medical Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed and burial-trail Division or Vital Records, P.O. Box 68760, physician attending þ signed l ate has bage 2 s this certificate ector.

Examine Physician/Medical þ Completed Be Certification: To To the Funeral Director.

To the Funeral Director. After th

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5 ☐ Pending investigation

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 □ Yes 2 □ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signatule and title of certifier

D0061199

29d. Date signed (Month, Day, Year)

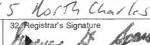
State Registrar

Medical

Black 31. Date filed (Month, Day, Year)

2007

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



ST. Suite 209, Tousur.

the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

4c. County of Death

1. Decedent's Name (First, Middle, Last)

ail

4a. Facility Name (If not institution, give street and number

an

Physician /Medical **Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene.

			= State Registrar Amend #30, pe				artment of He rtificate of F			giene Reg. No	2007	395	37
		ž	1. Decedent's Name (First, Middle, La		2/11/0/ 1	1001	timouto or E	- T	2. Date of Dea	ath		3. Time of	
	Physicia /Medic		Leah	L.	Cast	t1e			Dec.	6, Day	2007	9:50	p ^M
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ر معرفم		-	733 White Oaks		//www.lasthi	with olone (Cato	nsville If Under 24 Hrs.	8. Date of Birt	h	Baltimo		r Foreign
	Funeral Director			Sex 7. Age 1 □ M 2 🔯 F	73	Yrs.	Months Days	Hours Min.	July 1	, Year)	934 Mar	place (State on htry) yland	
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of His If Yes, specify Cubar 1 □ Yes 2√√2 No	Specify:	Rican, etc.)		Black, White, Specify: Whi	etc.	
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Maryland	ld be ental ked o	To Be	Alfredo	Lancio	tti			Kathe	rine		Dente		
ary	should be ind Menta marked umatic ev	-	19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailii	ng Address (Street a	and Number or Run	al Route Numbe	er, City or	r Town, State, Zip	Code)	
	1 and 2 s Health ar em 27 ls other trau		John R. Castle	Husband			Vhite Oaks					1228	
ore	of He fiter		20a, Method of Disposition 1 ☐ Burial 2 XCremation 3	Removal from State	20b. Place o	of Dispo ery, cre	osition (Name of matory or other place	θ)	Date	20c. Loc	cation - City or To	own, State	
Ĕ	Pages iment of I tant: If its jury or o		4 □ Donation 5 □ Other (Spec	ify)	Carro	_	Cremation	1			ostead,		
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lice	M. Jo	wkins		2. Name and Addres						
2			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	nplications that caused y one cause on each lir	the death. Do	not en	ter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and	tween
	Physician	5 1	Immediate Cause (Final disease or condition	a Brea	st (Can	cer					Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							2	23d. Date of deliv Month		Year
	v requires that the d been signed by the should be detached	b	Part II. Other significant conditions	contributing to death b	ut not resulting	in the u	underlying cause give	en in Part I.	23e. Did t		se contribute to t	the cause of the bably 4 🗆	
or Vital Records,		Completed							24a. Was autoj perfo 1∐ Yes		death?	opsy findings ompletion of c	available cause of
/ita	Physician: r this certific ral director,	Be (25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat	/				
or	this la	2	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ☐ ER/C	outpatie . Time o		4 LI Nursing Ho	ome 5 Resi 28d. Describe		6 □Other (Speci	fy)	
	dlng h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Da		Injury	Worl	(? Yes 2 □ No	Loui Doddingo		, 00001100		
Division	al or Attending F s after death. Il Director; After i id in by the funera	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of inju	ury - At home, t c. <i>(Specify)</i>	farm, st	reet, factory, office		28f. Location (City or To	Street an wn, State	nd Number or Flur)	al Route Nur	mber,
	To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination a	ge, dea and/or ii	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause((s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	The	M.().	D &	39 09			te signed (Month,	, Day, Year)	
	12		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type	, Print)						
	-8		Ting Bao, MD 31. Date filed (Month, Day, Year)	-R2 Renietr	ar's Signature								
	Sta Regist	ate rar	DEC 1 1 201	No.	15	base	le le						
				2									

DHMH 17 Rev 1/2001

07-09412 Maria Cox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aria Cox		State of Maryland / Department of Certificate of Certificate		rene Reg. No. 2007 3953			
Physici	an/	1. Decedent's Name (First, Middle,Last)	2.	Date of Death 3. Time of Death			
edical Exami	iner	Maria Elizabeth Cox		December 4, 2007 2005 hrs			
		Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery				
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign			
Director		578-90-8006 1 M 2 X F 48 Yrs Usual Residence of Decedent		Dec. 31, 1958 Country New York			
w any		10a. State 10b. County 10c. City, Town or Local	tion	10d. Inside City Limits 1 Yes 2 X No			
Maryland 28a-f show any d at once		Maryland Montgomery Silver Spri	ng 10f. Zip Code	10g. Citizen of What Country?			
n with the Maryland ms 23a or 28a-f sho be notified at once	Direct	2820 Munson Street	20902	United States			
215-0036 be filed within 72 hours after death with the Maryland mal Hygienen male Hygiene man Hygiene man watural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	uneral	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent E	as Decedent of Hispanic Origin? (Speci es, specify Cuban, Mexican, Puerto Ric	fy Yes or No- 14. Race - American Indian, Black,			
ter death ", or iter	ш	Never Married 2 X Married 1 Yes 2 X No	Yes 2 X No specify:	Specify: White			
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of wor	k done 16b. Kind of Business/Industry			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ance Agent	Insurance			
5-00 ed with tygiene other t	Com	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)			
	o Be	Charles E. Fullwood 19a, Informant's Name/Relationship (Type, Print) 19b. Mailin	Anne Sear	C.Y al Route Number, City or Town, State, Zip Code)			
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	ř		· ·	lver Spring, MD 20902			
			sition (Name of cemetery, Lither place)	20c. Location - City or Town, State			
Baltimore, permit. Pages 1 an Department of Hei Important: If ite		4 Donation 5 Other Specify: Parklawn Mer		12, 2007 Rockville, Maryland			
Bal permi Depar Impo injur		21. Signature of Funeral ervice Ucens RO MO0896 Ch	bert A. Pumphrey I ase, Inc., 7557 Wi	Funeral Home/Bethesda-Chevy sconsin Ave., Bethesda, MD			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or re	espiratory arrest, shock, or heart Approximate Interval Between Onset and			
aminer		immediate Cause (Final disease or condition resulting in death) a. In recent land the country as a consequence of its ease	sociated with hyperter	sive cardiovascular Death			
	L	Sequentially list conditions, b					
	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
V uted Id ansit	Exa	events resulting in death) Last Due to (or as a consequence of):					
60, tree be executed hysician and e burial - transit	ledical	X UNPENDED AMENDED, perME, G874, 12/1:	3/07 TT				
68760 certificate b nding physi	n/Me		etal death 3 Ectopic pregnanc	23d. Date of delivery Month Day Year			
Box 6876 he death certificate the attending phy hed for use as the	Physician/M	past 12 months? 1 Yes 2 No 9 V Unknown 1 Unknown	ther (Specify)				
O. B. at the de 1 by the tached f			underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by I director, page 2 should be detach	ed by			1 Yes 2 No 3 Probably 4 V Unknown			
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should 1	Completed		<u></u>	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
Re(r: The tiffcate or, page		25. Was case referred to medical	26.Place of Death (Check on	1 V Yes 2 No 1 V Yes 2 No			
Vital hysician this cer	To Be	examiner?	- IOthor: -	Home 5 Residence 6 Other:			
Of ng P After anera		(Month, Day, Year)	Injury 28c. Injury at Work? 2 1 Yes 2 No	8d. Describe how injury occurred			
Division all or Attendiins after death.	icati	2 Accident investigation 28e, Place of Injury - At home, farm, str		8f. Location (Street and Number or Rural Route Number, City			
Div pital or ours aft reral Di	Certification:	Suicide Could not be determined (Specify)		or Town, State)			
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: v	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occione) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, and d ation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)			
To 1 with To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
		Cerrol Hallan	O.C.M.E.	December 5, 2007			
6		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201				
,~ s	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	fresh				
Regis							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Cer	tificate of	Death	Reg.		39539		
Physici	an	1. Decedent's Name (First, Middle, Last) Willie Edwar					2. Date of Death Month	Day Year	3. Time of Death		
/Medic	cal				4h City Tourn o	r Location of Death	DECember	9 200 4c. County of Dea	2= 0		
Examin	ner	4a. Facility Name (If not institution, give s Sivai Hospital	of Baltimore		Baltimor	Cat .		N/A	ın		
Funeral			7. Age (In yrs. le	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
Director		219-38-3000	M 2□F 65	Yrs.	Months Days	Hours Min.	JAN 20 1	942 Mar	yland		
pur *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits		
f shore	5	MD N/A		ltimor					1 ∰Yes 2 No		
the N 28a-	Director	10e. Street and Number	Da.	TCTIIOT	10f. Zip Code		10g.	Citizen of What Co	ountry?		
h with	Ö	1124 Somerset Str	eet		21202			USA			
ems ?	Funeral	THE INTERNAL CHARGO	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Ame Black, Whit			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone.	þ	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	- 1	I □ Yes 2 No	Specify:	riodi, otc.,		31ack		
72 hc 'natuı	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occup	ation during most of workii d)	16t	. Kind of Business	/Industry		
within ene. than '	I I	Elementary/Secondary (0-12)	College (1-4or 5+)		ruction			Construc	etion		
filed Hygid ther smt, th		17. Father's Name (First, Middle, Last)		COLISE	Luction	18. Mother's Name	(First, Middle, Mai		.01011		
lid be lental ked c	To Be	Edward Davis				Maggie	Smith	·			
shou and M s mar umat		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailin	g Address (Street	and Number or Rura	l Route Number, C	ity or Town, State,	Zip Code)		
and 2 salth a n 27 is		Willa Mae Davis -				Street, 1	Baltimore	, MD 212	202		
ges 1 of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ R			sition (Name of natory or other plac			. Location - City or			
tment tant:		4 ☐ Donation 5 ☐ Other (Specify)	Met:			Inc. $12/10$		altimore,			
permit Depar Impor any Ir		21. Signature of Funeral Service Licens	en H. William	S 22	Crematio	s Society	of Maryl	and, Inc.			
FIEL		23a. Part1. Enter the disease, or compli	cations that caused the death.			erick Road			21228 Approximate		
Dhyololon		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		-,,	9,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death		
Physician / /Medical		disease or condition resulting in death)	Due to irr as a consequ	ence of):					19 days		
Examiner				-							
p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)									
ecute and trans	Examiner	that initiated events resulting in death) Last									
be exician a											
rtificate be executed ng physician and as the burial-transit	Medical										
eath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregnar		I			23d. Date of de	livery		
deatl	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/ 		Month	Day Year		
at the de	Phys	9 Unknown					T				
ires tha signed l	by	Part II. Other significant conditions con Multiple decub		iting in the un	iderlying cause giv	en in Part I.		/	o the cause of death?		
w require been sig should b	eted	41	Λ 1								
he law has b	Completed	Chronic respire	atory tallure				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of		
ilclan; The certificate h rector, page		25. Was case referred to medical				00 Disease (Desert	1 Yes 2		2 2 1 No		
/sicla	To Be	examiner?	lospital: 1 Inpatient 2 E	R/Outpatient	t 3 DOA Oth	er: 4 Nursing Hor		e 6 □Other (Spe	onifu)		
g Physical this reral dir		27. Manner of Death		28b. Time of Injury	28c. Injur Wor		28d. Describe how i		ecity)		
endin ath. or: Af he fur	atio	1 ☑Natural 5 ☐ Pending investigation	(Month, Day Year)	плогу		Yes 2 □ No					
or Atter ter de lirecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, stre)	eet, factory, office	2	28f. Location (Stree City or Town, S		ural Route Number,		
pltal o		200 Contillar 1 Department Physics	Malana Ta the best of my know	uladaa daath	a aggregate at the tie	ma data and place of		-/->			
e Hos 24 ho e Fun letely	Medical		sician: To the best of my know ner: On the basis of examinati and manner stated.								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director, after this certificate bas been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)		
		Much I	Anno MI	>	RI	ES - 000	D	ECember	9.2007		
3		30. Name and address of person who co			Print)						
		Nicole L. Strond	, MD Si	nai Ho	ispital of	Baltimor	e				
Sta Registr		31. Date filed (Month, Day, Year)	32 Hegistrar's Signat	ure do	ospital of						
	ui	DEC 1 1 200	II Julien	3 6							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5100 AM Dennis Decamer 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memoria Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 3-22-1954 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗗 Months 219-62-4356 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show altimore 1 es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wardbourne Ave alala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 20 No 1 ☐ Yes 2 ☐ NO Specify: Baltimore, Maryland 21215-0036 þ Black 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be 2 should be f and Mental I מאר ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Danny Wheeler item 27 i Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Baltmore, Mankent Greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bultimore National Pike Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cancer Lund 5 month /Medical Due to (or as a consequence of): **Examiner** Due t (or as a consequence of) thma Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed attending physician and for use as the burial-transit Box 6876076 Anemia Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? Yes 2 No certificate 1∏ Yes or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1X Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: Division Hospital or Attending 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Alcheikh MO 2438946 12/6/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 hospital, Baltimore, MD MD Union menorial Elic Alcheikh 31. Date filed (Month, Day, Year) DEC 1 1 2007 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #12, perFH, g874, 12/21/07 TT Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Vernon Sherwood Dorrough December 6 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4124 India Ave. Nottingham Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ★ M 2 🗆 F Director 223-34-9510 April 3, Va. Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes & No Director Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 4124 India Ave. 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes Sur If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 +Millwright Steel Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h Be Clarence V. Dorrough Eva Arbutus Comer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health Department of Healt In portant: if item 2: ary Injury or other one. Janet Dorrough/wife 4124 India Ave., Nottingham, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Mem'l Gdn. 12/10/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Brian 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assiration **Physician** Due to (or as a consequence II): 3 NUCKS disease or condition resulting in death) /Medical Examiner Due to (r a a a consession nce of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed rolusquerdira the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as een signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an After this certificate has funeral director, page 2 s autopsy performed? ial or Attending Physician; The safter death.

Is after death.

In Director; After this certificate of in by the funeral director, paged in by the funeral director director, paged in by the funeral director director director, paged in by the funeral director dir 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 178 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) loven my us December 10,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) DEC 1 1 2007



Paulsi Ballimore Maryland 2/2/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nut Examiner ecurity Numb 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F 62 212-46-8622 8-5-1945 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event the Madical Control of the statement of the Madical Control of the Madical Cont 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Pikesville Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 8322 Scotts Level Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specif African-American 1 ☐ Yes 2 No If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Asst. Living Manager 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Minor Willie A. Gilmore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8322 Scotts Level Road, Pikesville, MD 21208 Duane T. Day/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 12-8-2007 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** : 4 /Medical u⊮ o (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar a consequence of physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown for 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b 4 Unknown 2 No 3 Probably been signated by should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 has 1□ Yes certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 ☐ Yes 2[**X**No 1 Inpatient 2 ☐ ER/Outpatient ို this 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: 1 Natural 5 ☐ Pending investigation vithin 24 hours arter community the Funeral Director; Aff 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar

Q.

30. Name and address of person who completed ca

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 687605

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #23b&d Per Phy 6874 12911769 nt of Health and Mental Hygien O Certificate of Death Reg. No. Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Month Day **Physician** 0035 OANS HAMPton 2007 Ember /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner Alvery MEMPRIAL Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**≰** M 2□ F 7.26-2620 Yrs. Jestel 12, 1927 MARCI LAND Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c-City, Town or Location State 10b. County 28a-f show notified at 1 → Yes 2 No rederick Director alver MRI And 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 20678 MIRAROUND Funeral Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 Z Divorced HMELICAN Ki d of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life., DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12×6, 18. Mother's Name (First, Middle, Maiden Surhame) 17. Father's Name (First, Middle, Last) Be atherne ပ HENRY EVARS 19b. Mailing Address (Street and Number or Rural Route Number, City or Toyvn, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20639 Department of Health ar Important: If Item 27 is any Injury or other trau de 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Le Church Cemery December 15 w Hengtingtons MARGIAND 22. Name and Address of Fallity Unacy m. Wallace General See 1:12 3:405 W. FRANKIN Street Bathmore MARGIAND 21339 permit. ure of Funeral Service Ligensee 21. 5 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or furt failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of the consequence of Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence Examiner Vascular Disease Perpheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes signed by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 💢 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manne Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 □ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours at To the Funeral C completely filled i rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/10 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O Box 70 Huntingtown MARYland 20639

Registrar DHMH 17 Rev 1/2001

State

KIOUMARCE YAZDANI

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1 2007

31. Date filed (Month, Day,

egistrar's Signature

07-09473 Gracy Featherston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 39544

		For State	Cen	tificate o		Reg. No.				
Physician		Decedent's Name (First, Midd	dle,Last)				1.4	ate of Death onth Da	y Year	3. Time of Death 2205 hrs
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(4	a. Facility Name (if not instituti	ion, give street and number)		4b. City, Town	, or Location of	of Death		4c. County of	Death
		Johns Hopkins Hops	ital		Baltimore	Э				
Funeral	5	Social Security Number	6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1			Date of Birth (N	IM/DD/YYYY)	9. Birthplace (State or Foreign
Director			1 M 2 VF 71	Yr		Days Hours	Min.	1/09/19		Country) VA
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5-0036 iled within 7 Hygiene.	3	17. Father's Name (First, Midd	ile, Last)					st, Middle, Mai		
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Baltim permit. Pag Department Important; injury or o	1	21. Signature of Funeral Servi	Le Licensee		1905 V		1 001	Fimore	MI	21717
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trendi	<u>Ö</u>	1 Yes 2 No 9 🗸	4 Pregnant at time of o	death 5	Other (Specif	y)			Ì	
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Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certifurs after death. 1al Director: After this certificate has been signed by the attending lied in by the funeral director, page 2 should be detached for use as	Completed		diani l		26	Place of Dea	th (Check onl	ly one)		
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Oncor only	ng Physician: To the best of my knowle Examiner:On the basis of examination	edge, death o	courred at the t	ime, date and	place, and di	ue to the cause he time, date a	e(s) and mann and place, and	er as stated. due to the cause(s)
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F 3 F 8	Me	29b. Signature and title of ce				License numb	per			ned (Month, Day, Year)
		m	hu, miD		1	O.C.M.E.			Decembe	er 7, 2007
		30. Name and address of pe	erson who completed cause of death (It	em 23a)						
20			istant Medical Examiner 1	11 Penn S	treet, Baltin	nore, MD 2	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 5:55 P.M Nancy Lee Griffith 2007 /Medical 4b. City, Town, or Location of Death TOWSON 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7/14/1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 1 F 216-32-2772 72 Balt., Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State Maryland 10c. City, Town or Location Cockeysville 10b. County Baltimore r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo filed within 72 hours after death with the 10g Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21030 America 531 Penny Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2/5 No 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Insurance Office Manager 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked other any injury or other traumatic event one. Be Nancy Lee Bradley Conrad Daniel McClung 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 531 Penny Lane Cockeysville, Maryland 21030 Susan E. Sunday/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel— Bel Air December 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9, 2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses Peaceful Afternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4095 Physician Song 11 Cell Ling /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the sahould be detached to 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Stonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed 2 No 1∐ Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospite 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death After 1 Natural Injury 5 ☐ Pending 1 Yes 2 No investigation after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St, Scite 209, Towson MO 21204

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Director 217-12-00	do2 10 M 219 8		Hours Min. (Mont)	Day, Year) 3. Birthplace (State of Poreign Country)
Usual Residence of Dec	c. County 10c. City	, Town or Location		10d, Inside City Limits
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11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Specify Yes o Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc.
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Tary and Monday and Mo	Relationship (Type, Print)	19b. Mailing Address (Street and		umber, City or Town, State, Zip Code)
e B e di	apper/Granddaynta	alo Louise /	Ave. Baltim	20c. Location - City or Town, State
To be an incident of the second of the secon	emation 3 Pemoval from State	emetery, crematory or other place)		
21. Signature of Funeral		22. Name and Address	of facility Crematio	
· acc	sease, or complications that caused the death			Vike Baltimore MD 21229 ory arrest. Approximate
Shock, or heart fail Immediate Cause (Final disease or condition	ure. List only one cause on each line.			Interval Between Onset and Death
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To he have been a second of the second of th	1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?		Residence 6 Other (Specify) ribe how injury occurred
Division of Vital Records, or attending Physician: The law requires the role of the function of Vital Records. In by the functal director, page 2 should be completed by the function of the	investigation Could not be	M 1 TYes	s 2 □No	(Standard Alimbara Carl Carl Alimbara
DIVISION DIVISION 27. Waxue of Death 1	building, etc. (Specify	me, farm, street, factory, office)	City o	ion (Street and Number or Rural Route Number, r Town, State)
a 29a. Certifier 12	Certifying Physician: To the best of my know Medical Examiner: On the basis of examinati	wledge, death occurred at the time, ion and/or investigation, in my opini	date and place, and due to ion, death occurred at the t	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
A company of the comp	and manner stated.	29c. License n	umber	29d. Date signed (Month, Day, Year)
Manna			=5000	12/04/2007
30. Name and address o	of person who completed cause of death (Item A FANGTHAM 5	23a) (Type, Print) 601 Luch Rui	ven Rlvd	Baltimore, MD. 21239
State 31. Date filed (Month, Da			our piry.	111111111111111111111111111111111111111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Dolores A. Greffen 3-31 AM DECEMBER 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Mar. | 18, 1 ST AGINES Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 70 Yrs. 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 1 X F 223-46-3849 1937 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 □Yes 2X No MD Howard Elkridge ns 23a or 28a-f sh must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6415 Abel Street 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No white Baltimore, Maryland 21215-0036 ò Specify: Completed by 3 Widowed 4 ☐ Divorced natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Funeral 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wiley Denney Della Brown ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat 6415 Abel Street Elkridge MD 21075 Victoria Williams/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 12-7-2007 Park Ambrose runeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Signature of Funeral Se License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMBOLISM PULMONARY I DAY **Physician** /Medical Due to (or as a consequence of) 2 DAYS Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Veal Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ PARKINSON'S DISEASE 3 ☐ Probably 4 ☐ Unknow 1 ☐ Yes 2 ☑ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2☒No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 N Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No thours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3∏ Suicide 4 Homicide 24 hours a 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division or Vital Records, P.O. within 24

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier MEDICAL INTERM

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVENUE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BALTIMORE 2122

DIMAN AMICHHAME

32. Registrar's Signature Batwa

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician Homens 2007 liam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Kiver suckle 6. Sex Honey Lane Ylid If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☑ M 2 ☐ F 212-30-6148 Baltimore NOV 8,1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show notified at 1 ☐ Yes 2 No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō other traumatic event, the Medical Examiner must be 21220 3303 items 23a SUCKIE -ane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: 2 white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) marked other than tified Welder Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Homens Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) iddle River Hd 21220 50 f Health Helen E. Homens 3303 Honeysuckle ane Pages 1 and Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gargens of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State White Marsh Md 12/12/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chapel + Cremation Services 21. Signature of Funeral Service Licensee Evan 1 21234 8800 Harford Road lai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART CONGESTIVE YEM Physician /Medical Due to (or as a consequence of): Examiner ATHEROSCLEROTIC CORONARY Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execute burial-transi and Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 ☐ Other (specify) 1□Yes 2□No P.O. 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. CHRONIC FAILUNE 1 Yes 2 No 3 Probably 4 Unknown Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was autopsy performed? 1∏ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 24 hours after death e Funeral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DEC 1 1 2007

FERNANDO

31. Date filed (Month, Day, Year)

FERRO 32 Registrar's Signature

Zanomo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

040480

7602 Belair

DECEMBER

ROGA

21236

2007

HENRY, CHARLES Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		For State	State of	Marylan	d / Depa	artment of H	lealth and	Mental Hy	giene	2007	39552
		Registrar	(4)		Cel	rtificate of	Death		Reg. No.		1
Physici /Medic		1. Decedent's Name (First, Middle, Charles Leonard		c.				2. Date of De Month Decemb	Day	9,2007	3. Time of Death 12:23P M
Examir		4a. Facility Name (If not institution,	-	*		4b. City, Town, o	r Location of De	ath	4c. (County of Death	<u> </u>
		Greater Baltim	ore Medic	al Cent	ter	Towson	1		F	Baltimor	e
Funeral Director		121 02 1320	3. Sex 1 M 2 F	7. Age (In yrs. I 57	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th Year)	9. Birth Cour Sewa	place (State or Foreign ntry) nee , Tenn .
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin	nore Count		r, Town or Lo Ockeys						0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 10400 Greenside	Drive	-		10f. Zip Code	21030		_	en of What Cou ted Stat	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced	Armed For	2 ∕∆ No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21☐ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
72 hc natur	ec	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Usual Occup	ation	varkina	16b. Kin	d of Business/In	dustry
d within giene. ar than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	_	kind of work done of DO NOT use retired uction St		1		Theate	r
uld be file Mental Hy rked othe tlc event,	To Be C	17. Father's Name (First, Middle, Last) Charles Leonard Henry, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Carolyn Turner			Surname)	
and 2 sho salth and ? n 27 is ma		19a. Informant's Name/Relationship Mrs. Jane Morgan		ife)		ng Address <i>(Street i</i> 0 Greensi		Rural Route Number 7e Cocke		Town, State, Zip	
Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		CE	emetery, crer.	sition (Name of matory or other plac eral Char	pel Dec.	Date 12,2007		eation - City or To	wn, State , Marylarid
permit. Departi Importi any Inj		21. Signature of Funeral Service Li	F-ga	in, 1	z. Pê	aceful ^{Add} 325 York	ternati Road	ves Fune Timonium	ral&C , Mar	Crematio Cyland	n Ctr., P.A. 21093
Physician	e 9	23a. Part. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that can ly one cause on ea	used the death ach line.	Do not ento	er the mode of dyin	ig, such as cardi	iac or respiratory an	rest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (c	or as a consequ	ence of):	Pren	2160				
nd A harmonit	Examiner	Esquerifially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
leath certificate be executed attending physician and for use as the burial-transit	edical Ex	resulting in death) Last	Due to (d	or as a consequ	ence of):						
entifica ing ph		IF FEMALE:		-							
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 ☐ Fetal ant at time of de	déath 3□	Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ery Day Year
that the ed by detax		Part II. Other significant condition	s contributing to dea	ath but not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco us	e contribute to the	ne cause of death?
w requires that the dibeen signed by the should be detached	ted by							101	∕es 2Æ	No 3□ Prot	ably 4 Unknown
Physician: The law this certificate has b ral director, page 2 sh	Completed							24a. Was autop perfo 1 Yes		prior to co death?	psy findings available inpletion of cause of 2 No
Ician Sertifi ector	Be	25. Was case referred to medical examiner?	Haanitali	·		1011		eath <i>(Check only o</i>	ne)		
Phys this al dir	၉	1 Yes 2 No			R/Outpatien		4 🗆 Nursing	Home 5 ☐ Resid			y)
ending I sath. or: After he funer	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	ion	n, Day Year)	28b. Time of Injury	28c. Injury Work M 1 ☐ `	/at <br Yes 2 □ No	28d. Describe h	ow injury	occurred	
rs after d ral Direct led in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine	ed 28e. Place of building	g, etc. (Specify,		eet, factory, office		City or Tou	rn, State)		l Route Number,
he Hosp in 24 hou he Funer pletely fill	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the backaminer: On the backaminer	sis of examinati	vledge, death ion and/or inv	occurred at the time vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and	and manner as s place, and due to	tated. the cause(s)
To t To t	×	29b. Signature and title of certifier	man	MO		29c. License				signed (Month,	
10	-	30. Name and address of person wh	no completed cause	of death (Item	23a) (Type, F		21 C+				2,2211

State Registrar 31. Date filed (Month, Day, Year)
DEC 1 1

36 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CYNTHIA SOTIANO MD 6701 N. CHATES ST. Baltimore MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Dee 2007 William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner altimore Hospice Gilchrist enter O Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 € M 2 ☐ F Yrs Aug 26, 1937 Baltimore, Md 212-36-0880 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21161 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∰Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗌 No 1 ☐ Yes 2124No Saltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Firetighter-Kump Operator Department 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be era A 1+. Hogan ဥ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WhiteHall ma Lee Hogan - spouse sandra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12/10/2001 12/10/2001 22. Name and Address of Facility Evans Funeral Chapel + Cremation 8800 Harford Road Parkville (Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GARS METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending phy of for use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autonsy perform certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3□ DOA 2 ဥ 1 | Yes this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

within 24 hours after death To the Funeral Director:

10

Registrar

DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) State

29b. Signature and title of certific

6565 32. Registrar's Signature

2007

eted cause of death (Item 23a) (Type, Print)

N CHARLES STREET, SUITE 209 BALTIMINE MD, 21204

29c. License number

D64395

29d. Date signed (Month, Day, Year)

DECEMBER 7,2007

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/illiam Edwin Mu			2007 2055									
	F	1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death	lo.									
Physicia Nedical Examir	_	Month Day	y Year 1839 hrs									
			4c. County of Death									
		Northwest Hospital Center Randallstown	Baltimore County									
Funeral		Months Days Hours Min	M/DD/YYYY) 9. Birthplace (State or Foreign									
Director		213-59-6629 1X M 2 F 67 Yrs. OCT 17	1940 Country India									
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
8 .		MD Bolleimann Cohomoreillo	1 Yes 2 X No									
Maryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?									
the M a or 2 tiffed	ğ	1229 N. Rolling Road 21228	USA									
death with the M or items 23a or 2	ərai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.									
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5-0036 led within 72 hours after death with the Maryland ttygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	<u>a</u>	3 Wildowed 4 Divorced in tes, divorted or Dates:	Specify: Asian b. Kind of Business/Industry									
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thin 7 than than tedica	Completed	12 Accountant, sales associate	Civil Engineering									
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121 d be fi ental] arked	Be											
nore, MD 21215-0036 ages I and 2 should be filed within 7 nt of Health and Mental Hygiene. It I filem 27 is marked other than other traumatic event, the Medica	٩	19a. Informant's Name/Relationship (Type, Print) Joy William – son 19b. Mailing Address (Street and Number or Rural Route Number										
	ŀ	20a, Method of Disposition 1mk 20b. Place of Disposition (Name of cemetery, 2011) Date 20	Oc. Location - City or Town, State									
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State										
litin	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Williams 22. Name and Address of Facility MacNabb Funeral Home, P.A.	ntonsville, MD									
Dep Dem		1 SUL Frederick Road, Catonsv	ville. MD 21228									
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line.	Between Onset and									
/Medical		Immediate Cause (Final disease a. Cardiac Tamponade	Death									
		or condition resulting in death) Due to (or as a consequence of): B. Rupture of Myocardial Infarct										
	Jer	Sequentially list conditions,										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Disease Order of the Corps as a consequence of the Co	Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):									
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68760, certificate be ex nding physician se as the burial -	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delivery Month Day Year									
x 687 h certifu tending use as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Month Day Year									
Box e death of the attented for us	ysic	1 Yes 2 No 9 Unknown g Unknown										
that the			2 No 3 Probably 4 Unknown									
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detace.	ed by	1Yes	24b. Were autopsy findings available									
ords, w requir as been s	Completed	24a. Was an autopsy performs	prior to completion of cause of									
Rec The la icate h	mo;	1 ✓ Yes 2										
Vital Reysician: The his certificate director, page	æ	25. Was case referred to medical examiner?	esidence 6 Other:									
f Vi Physi er this	유	O 1 V Yes 2 No 1 inpatient 2 V Erroutpatient 3 DOA 4 Norship Home 5 Inter-										
ion of tending Ph. eath.	ion:	1 Natural 5 Pending (Month, Day, Year)										
ivision or Attencath after death Director:	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street, factory) of the building of Town, State of Town, St	eet and Number or Rural Route Number, City									
Div pital or ours aft ceral Di	Certification:	3 Suicide 6 Could not be determined (Specify)	e)									
			s) and manner as stated.									
To the How within 24 h To the Fur completely	Medical	(need only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	29d. Date signed (Month, Day, Year)									
	Σ		December 9, 2007									
		Car de Hacea	2000111001 0, 2001									
5		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
St	ate	At a second seco										
Regist	trar	te 31. Date filed (Month, Pay Year) 2007 (32. Registrar's Signature)										

OCME

7-09311	-11	Please Type or Print in Black Indelibl r. State of Maryland / Departmen			^{e.} 2007 3955
ryan Edward H		- For State Certificate	e of Death	Reg. No	
Physicia		tegistrar 1. Decedent's Name (First, Middle,Last)	2	. Date of Death	3. Time of Death
Exami	ner	Bryan Edward Hall, Jr.		Month Day December 1, 2	
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Halethorpe		4c. County of Death Baltimore County
		920 Catawba Court 5. Social Security Number			W/DD/YYYY) 9. Birthplace (State or
Funeral Director	1	210 22 2126	Months Days Hours Min.	March 1,	Foreign Washington
	ŀ	219-33-3136 1\(\overline{X} \text{M} 2 \overline{F} \overline{1} \text{8} \\ Usual Residence of Decedent	Yrs.	,	DG
an y	ł	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
*	اڃ	MD Baltimore Haletho	rpe		1 Yes 2 X No
faryla 28a-f 1 at or	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ă	920 Catawba Court	21227		S.A.
th witl	Funeral	1 Y Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
er dea	Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: white
ırs aft ınral" ımine	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation (Give kind of w		o. Kind of Business/Industry
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working life. DO NOT use retire		_
036 rithin and tedic	Completed	12	dent		tudent
15-0 iled w Hygid d other	ပိ	17. Father's Name (First, Middle, Last) Bryan Edward Hall, Sr.		(First, Middle, Maid ye Lynch	en Surname)
121 Id be f fental narke event	o Be		Mailing Address (Street and Number or R	, ,	, City or Town, State, Zip Code)
ID 2 shoul and N 77 is m	Ĕ		Catawba Court Balt		
and 2 lealth item 2 traus		20a Method of Disposition 20b, Place of I	Disposition (Name of cemetery,	Date 20	c. Location - City or Town, State
ages l nt of H other		1 XBurial 2 Cremation 3 Removal from State MeadOW	or other place) cidge Memorial 11-6	5 - 2007 E	lkridge, Maryland
ultin nit. P artme sortan ury or	. (2 Signature of Funeral Service for niee	Ialk	1	ral Home of Lansdown
E P P D			2719 Hammonds Ferry	Rd. Lans	shock, or heart Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
executed an and al - transit	cal Examine	events resulting in death) Last Due to (or as a consequence or): d.			
9 5 7	ed:		g876, 2/4/08 IT		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exervitin 24 brous falser death. To the Faureral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	incy	Month Day Year
D. BC t the der by the a	Physici	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
P.O.	ρ			1 Yes	2 ✔ No 3 Probably 4 Unknown
Division of Vital Records, P.C ta or Attending Physician: The law requires that is after death. The Director: After this certificate has been signed ted in by the funeral director, page 2 should be deta	Completed			24a. Was an autopsy performe	
tal Rectian: The	ភូ	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2_	No 1 Yes 2 No
'ital sician is cert irecto	l a	examiner? Hospital: 1 Innation: 2 FR/Out	I Oth and		sidence 6 🗸 Other: Scene
of Vital Recoling Physician: The law After this certificate has funeral director, page 2 s	ļ.	Tes 2 No	me of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred
on on ending ath.		Natural 5 Pending Fad 12/1/2007 Fad	9:45 am	unk	
Vision Att	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rural Route Number, Cit e)
pital o	er	4 Homicide determined (Specify) house		920 Catawba	a Ct. Halethorpe, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and	due to the cause(s at the time, date and	s) and manner as stated. d place, and due to the cause(s)
To the within To the complete	Medical	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	≥	29b. Signature and title of certifier	O.C.M.E.		December 2, 2007
		Maryone Me Wrell	J. J.M.E.		
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201	
	tate		4 sell		
Regis		11. 1'7 2011/ and an			OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 December Alfred Hasenei 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Baltimore FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** Months Min. 1**∑** M 2□ F 09-12-1927 Maryland 215-22-5640 80 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21128 4810 Berryhill Cir. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White Maryland 21215-0036 ò 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie (Unknown) James Hasenei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 5003 Leasdale Rd Baltimore, MD 21237 Kelly Hasenei (Daughter) Health a permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12-10-2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Woodlawn Cemetery 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 hr SCPSIS Physician /Medical Due to (or as a consequence of): undetermined Examiner FIBRILLaTION aTriaL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner = 24 hr assisted ventilator requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ttending physician AD Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPATITS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No (R) replacemen T 11,0 24a. Was an RECENT autopsy performed? Yes 2 No ì L eus 1⊟ Yes COLONIC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide io the howithin 24 hour.
To the Funeral Directory filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

V

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State Registrar

Ormerceder Terrell 31. Date filed (Month, Day, Year)
DEC 1 1 2007

9000 FRanklin 32 Registrar's Signature

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

RESOUG

Square Dr Baltimore

06

21237

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 39557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9, 2007 Year Nannie L. Hilderbrand December 12:50 P.^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12020 Suffolk Terrace Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Director 77 214-30-0002 July 18, 1930 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2√ No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 12020 Suffolk Terrace 20878 Funeral United States permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or increasing injury or other traumatic every any injury or other traumatic every items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Hayton Sula Ann Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Hilderbrand / Husband 12020 Suffolk Terrace, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Dec. 14, 2007 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servial Robert A. Pumphrey Funeral Home/Rockville, Inc. м00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 tie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Fillal **Physician** Stroke 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No ed by the 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 ☐ Unknown been si should I Cirrhosis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autonsy performed's 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 ☑ No this 28a. Date of Injury 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21340 December 10, 2007 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass, M.D., 15225 Shady Grove Rd. #302, Rockville, Maryland 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** December 9, AM Elizabeth F. Haggerty 2007 1:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🕱 F 036-09-5526 88 Director July 19, 1919 Rhode Island Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County aţ r 28a-f sh notified 1 Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r 20906 14400 Homecrest Road, #127 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fin and Mental h æ Angie William Pierce, Sr. Nora Walsh ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is I 4100 Everett St, Kensington, Maryland 20895 Kathleen Haggerty / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec. 11, 2007 | Bethesda, Maryland 4 Donation 5 ☐ Other (Specify) Montgomery Crematorium 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc 3207557 Wisconsin Ave. of Funeral Service Ligensee 21. Signature Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-350 M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a I ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2X No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 StOther (Specify) Hospice 1 ☐ Yes 2 ☑ No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pending investigation 1 X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. I Division or Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

wouldne

29c. License number

🛮 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

December 9, 2007 D0064615

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D. 1355 Piccard Drive, Rockville, Maryland 20850 Genevieve Anne Wroblewski 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Ree H111 Margie 2007 December 6. /Medical 3:15 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2509 Romoma Dr. 6. Sex District Heights Prince Georges If Under 1 Year If Under 2 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√F Director North Carolina 65 Jan. 10, 1942 230-52-6983 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. **Funeral Director** 1 ☑ Yes 2 ☐ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 58th Street N.E. #106 United States 20019 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည White Dawes Almena Arrington Finch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 Parkwood Street Hyattsville, Md. 20784 Donnie T. Arrington/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State *4⊡Donation 5 □ Other (Specify) Cedar Hill Cemetery 12/11/2007 Suitland, MD. 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Licen 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death e, of complica List only one Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER DF LUNGS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unverlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 12 No 2 No 1⊟ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident fter death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitalle within 24 hours of To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) DEC 1 1

29b. Signature and title of certifie

EUNEAUN MD

30. Name and ad ro's of person who completed cause of death (Item 23a) (Type, Print)

·VERGARA-SOARES egistrar's Signature

FRANKLIN SOLLARE DR. BALTIMORE MD 21251

216619

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5&19a Per INF G875 108 08 JH Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Irby 7:20 AM December Thest 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a_Eacility Name (If not institution, give street and number) Examiner 10 5. Social Security Number 248-76-8524 7. Age (In yrs last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 M 2□ F 10-14-1949 58 SC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show idicai Examiner must be notified at 1. Yes 2 No Director SIMPSONVILLE SC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29680 USA 504 HUDDERS CREEK WAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than V.P. COMMUNITY REINVESTMENT BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any liquy or other traumatic event once. Be MARY ELIZABETH HILL KEN HAYES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violeita Smith Irby/Wife
20a. Method of Disposition 504 HUDDERS CREEK WAY, SIMPONSVILLE, SC 29680 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State RESTHAVEN MEM. CARDEN 12-13-2007 PIEDMONT, SC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician lactic acidosis week /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CMV certificate be executed physician and s the burial-transit Pheumonitis Division or Vital Records, P.O. Box 68760亿 Due to (or as a consequence of): utoimmune Hepetitis Physician/Medical attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Medical Doctor Res-000 December 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore MD 21287 Miguel Munoz, 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

DEC 1 1 2007

			Stat	e of Maryland	-				200	7 39561
			Registrar		Cer	tificate of L	Jean,	2. Date of Dea		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Month	Day Yea	ır
	/Medic		Ralph Lewis Isenburg 4a. Facility Name (If not institution, give street ar	d number)		4b. City. Town, or	Location of Death	Decemb	er 5, 2007 4c. County of De	
	Examin	er	Montgomery Hospice Cas			Rockvi]			Montgome	erv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year		8. Date of Birth	9. F	Birthplace (State or Foreign
	Director		002-16-1959 1A M 2]F 84	Yrs.	Months Days	Hours Will.	Nov. 22	, 1923 Ne	Country) w Hampshire
	pu ,		Usual Residence of Decedent	10c City	Town or Loc	ration				10d. Inside City Limits
	arylar show	_	10a. State 10b. County							1 X Yes 2 No
	he M 28a-f otifie	ectc	Maryland Montgomery 10e. Street and Number	Roc	kvi11	e 10f. Zip Code			10g. Citizen of What	Country?
	a or a	ä	906 Allan Road			20850			United St	
	leath ns 23 must	Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.S.	13. V		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian,
0	ifter d r iten iner	표	Ami	ed Forces? Yes 2 ☐ No es, Give WWTT		Yes, specify Cuba	Specify:	Hican, etc.)	Black, W Specify: \[\bar{\cut}\]	
2-002p	ours a	ğ	3 ☐ Widowed 4 ☐ Divorced Yea	es, Give WWII		LI TES ZIAINO	эреспу.			
2	72 hc 'natur dical	Completed	15. Decedent's Education (Specify only highest grade compl		(Give i	ent's Usual Occup kind of work done	during most of work	king	16b. Kind of Busine	
V	vithin ne. han '	ld m	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)		OO NOT use retired F Modical	•	anhor	National Instit	
7	Hygie Hygie Sher ti nt, th	S	17. Father's Name (First, Middle, Last)	2	CIIIe.	i Medical	Photogr 18. Mother's Narr		Maiden Surname)	·ucc
and	the factor of the control of the con	Be					Julia	Spear		
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", aritems 23a or 28a-f show arimatic event, the Medical Examiner must be notified at	P	Phillip Isenburg 19a. Informant's Name/Relationship (Type. Prin	t)	19b. Mailin	g Address (Street			er, City or Town, Stat	e, Zip Code)
<u>8</u>	nd 2 :		Eleanor K. Isenburg/Wi	fe	906 A	Allan Roa	ıd, Rockv	ille, Ma	aryland 20	850
ē,	item item othe		20a. Method of Disposition	cei	metery, ciren	sition (Name of natory or other place	Dece	mber 18,	20c. Location - City	or Town, State
aitimor	Page nent c int: If		1 🕅 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (<i>Specify)</i>	Arl		n Nationa etery		007	Arlington	, Virginia
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Licensee	M01	346 R	Name and Addre	ss of Facility Rol Inc. 30 MD 2085	oert A. O West N O	Pumphrey lontgomery	Funeral Home/ Avenue
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.						Approximate Interval Between
	Physician			Salivary Ca	ncer v	with Meta	stasis t	o the B	rain	Onset and Death
	/Medical		reculting in death)	ue to (or as a conseque						
	Examiner	L.	Sequentially list conditions, b.	ual) (or as a conseque	ofi					
- 6	ed sit	ine	Sequentially list conditions, in any, leading to minimum acause. Enter Underlying Cause (Disease or injury	ma 10 (2), as a coursedne	ence orj.					
	xecut and	Examiner	that initiated events c	ue to (or as a conseque	ence of):					
8/60	death certificate be executed e attending physician and of for use as the burial-transit	dical E	d							
Õ	ificate g phys as the	edic			·					
ROX	leath certific attending p I for use as	N/N	23b. Was decedent pregnant	es, outcome pf pregnan Live birth 2 🗆 Fetal	icy death 3□	⊒Ectopic pregnanc	v		23d. Date of Month	delivery Day Year
	deal	sicie	1 Yes 2 No	Pregnant at time of dea		Other (specify)			World	Day Tou
J.	at the de	Physician/Med	9 ☐ Unknown Part II. Other significant conditions contributin	a to death but not result	ting in the Lu	nderlying cause giv	ven in Part I	23e. Did 1	obacco use contribut	te to the cause of death?
Š	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing	g to death but not resul	ang m me u	ndenying oddoe gn	on mr are is		Yes 2∐No 3∐	**
ecords,	requ	eted						24a. Was	an 24h Wer	e autopsy findings available
Ž	The law te has i	Completed						auto perfe	psy prior ormed? d <u>ea</u> t	r to completion of cause of the
Vital R			25. Was case referred to medical				26. Place of Dea	1 Yes	2 X No	Yes 2 No
	rsicia s certi lirecto	o Be	examiner? 1 Yes 2 No Hospita	: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Oth				Specify) Hospice
0	g Phy er this eral d	n: To	27. Manner of Death 28a		28b. Time o Injury				how injury occurred	· · · · · · · · · · · · · · · · · · ·
lo	ath. rr: Aft	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Monar, Buy Year)	,,		Yes 2 □ No			
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	Place of injury - At hor building, etc. (Specify,	me, farm, str)	reet, factory, office		28f. Location (City or To	Street and Number o wn, State)	or Rural Route Number,
	oital c		29a, Certifier 1X Certifying Physician:	To the heat of my know	ulodge deat	h occurred at the t	ime date and place	and due to the	cause(s) and manne	er as stated.
	Hosp 24 hol Fune stely f	Medical	(Check only 2 Medical Examiner: O	n the basis of examinati d manner stated.	ion and/or in	ivestigation, in my	opinion, death occ	urred at the time	, date and place, and	I due to the cause(s)
	o the ithin of the o the o the omple	Mec	29b. Signature and title of certifier	(M)	/	29c. Licens	se number		29d. Date signed (M	Month, Day, Year)
	⊢ ≮ ⊢ ŏ		Sevenie e la 1	roleller de	su.)	D0064	615		December	5, 2007
7	nH		30. Name and address of person who complete	d cause of death (Item	23a) (Type,	Print)				
	241		Dr. Genieve Wroblewsk	i, 6001 Mu	ncaste	er Mill R	d., Rock	ville, N	1D 20855	
-	/ St	ate trar	31. Date filed (Month, Day, Year) DEC 1 1 2007	32. Riegistrar's Signat	ure	parks				

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State of Maryland / Department of Health and Mental Hygiens 77

		-	For Stata Registrer	-	Department of Health and I Certificate of Death	Mental Hygien Reg. N	2001 33302
	Physicia		1. Decedent's Name (First, Middle, Las)		Date of Death Month D	year 4'00AM
	/Medic Examin	al .	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	12-7	c. County of Death
		4	1420 N.Linux 5. Social Security Number 6. Se	X 7. Age (In yrs, last birt			9. Birthplace (State or Foreign Country)
	Funeral Director		228-28-3467		Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 12-6-1	922 N'Cardina
	viand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	an Man Ba-f sh	ctor	MD	Bal	timore	100 (1
	3e or 2	Funeral Director	1420 N. Linwo	on Ale	10f. Zip Code 2.1 2.1 3	log. C	USA
	tems 2	uner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinat must be indiffed at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
ιĊ	"natur	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)		Kind of Business/Industry
2121	se filed within al Hygiene. I other then "	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Server		700D
and	s 1 and 2, should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Is marked other then "naturel", or Items 23e or 28e-f show item 27 Is marked other then "naturel", or Items Item Indifferent treumetic event, I'm Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	Fiec		me (First, Middle, Maid Ce Hick	
Maryland	2.shoul and Me Is mark eumeti	၉ .	19a. Informant's . ame/Relationship (7	ype, Print) 19b.	Mailing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip Code)
-	thealth item 27 other tr		20a. Method of Disposition		H20 N· Unwood Disposition (Name of	Date 20c.	Location - City or Town, State
altimore			1 Burial 2 ☐ Cremation 3 2 4 ☐ Donation 5 ☐ Other (Specify	Removal from State New 7	in Bartist Church	1/2007 MI	How, N. Carolina
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	fr mo13 63	22. Name and Address of Facility	cense Fun	MD 21212
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the death. Do none cause on each line.	not enter the mode of tying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
N.	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a DEMENTIA			2 YEARS
	Examiner			Due to (or as a consequence	or):		
7	bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		
ó	be executed ician and burial-transit	Exan	that initiated events resulting in death) Last	c	of):		
68760,	phys phys the	edical		d			
Box (eath certif attending I for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
	at the dea by the att tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		,
s, P.O	es that igned by be deta	by Ph	Part II. Other significant conditions of		n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
Division of Vital Records,	w require been si should l	eted	HYPERTENSION	3		24a. Was an	24h. Ware autopsy findings available
Re	: The taw cate has b	Completed				autopsy performed 1 Yes 2 X	prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one) Home 5 × Residence	6 □Other (Specify)
of	ding Phys	n: To	1 ☐ Yes 2 (∑No 27. Manner of Death	28a. Date of Injury 28b.	Itpatient 3 DOA Time of njury 28c. Injury at Work?	28d. Describe how i	
sior	tent featl tor: the	icatio	1		M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or Rural Route Number,
DİV	al or Attens s after deat of Director: ed in by the	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, S	tate)
	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	edical (29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Exer	ysician: To the best of my knowledgeninar: On the basis of examination are and manner stated.	e, death occurred at the time, date and plan d/or investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2. To the Complet	Mec	29b. Signature and title of certifier		29c. License number	1	Date signed (Month, Day, Year)
	1		Jam for t	MI MI	D 62032	DE	CEMBER 4 2007 CTIMORE MD 21224
	4		1	completed clause of death (Item 23a) ASH1 SSOS Ho	PKINS BAYVIEW	CIRCLE, BA	CTIMORE MD 21224
	Sta	atė	31. Date filed (Month, Day, Year)	3. Registrar's Signature	Social s	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma		/ Depa	artment of I	Health a			•	20562
			1 - State Registrer			Ce	rtificate of	Death		Reg. No	2001	39563
П	Physici		1. Decedent's Name (First, Middle, Las	Tou 181	5 .				2. Date of		Year	3. Time of Death
	/Medio Examir		4a Facility Name (If not institution, give	street and nymber)	1	4	4b Oty, Town,	or Location 9	of Death	40	: County of Dea	ath
ah.			Maryland (7cne	ral HOSP	stal		Baltim	pre l	ity			
	Funeral Director		5. Social Security Number 6. S 1 237-54-6558	ex 7. Afg	e (In yrs. last 70	birthday) Yrs.	Months Days		Min. (Monti	of Birth h, Day, Year	9. Bi	rthplace (State or Foreign country)
			Usual Residence of Decedent						MAI	2, 193		NC
	ehow	'n	10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 X Yes 2 ☐ No
	the N	Director	MD 10e. Street and Number		BA	LTIMO	10f. Zip Code			10a. Ci	tizen of What C	
	in 72 hours after deeth with the Marylan "naturet", or fteme 23e or 28a-1 ehow oldset Examilian mant be notified at	al DI	1211 ASHLAND AVEN	UE .				L 20 2			USA	
	ar dee	uner	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of I	Hispanic Original	gin? (Specify Yes o	or No-	14. Race - Am Black, Wh	
36	irs afte	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	10		1 ☐ Yes 2 📉 No				Specify: R	LACK
21215-0036	within 72 hours after deeth with the Maryland she. then "naturel", or iteme 23s or 28s-1 show he Mcdicel Examiner must be notified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra	ucation	1	6a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation	t of working	16b. k	Cind of Business	
2	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)			id)	t of working			
	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)	4		1	PASTOR	18. Mothe	or's Name (First, Mi		CHURCH Sumame)	
/lan	uld be Mental rrkad c	To Be	JEREMIAH JONES						IA CROSSO		,	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie markad othar then any injury or othar traumatic evant, the Magnes.		19a. Informant's Name/Relationship (1	ype, Print)	1				or or Rural Route N			-
	1 and Health Iem 27		ANN JONES/WIFE 20a. Method of Disposition		20b. Place	e of Dispo	L ASHLAND	1	BALTIMO Date	-	D 2120 ocation - City o	
Baltimore,	Pages nent of int: if it iry or o		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify		ceme	etery, crer	natory or other pla	· · ·	12-15-07			E, MARYLAND
alti	permit. Departmimports any inju		21. Signature of Funeral Service Licen			22	2. Name and Addre	ess of Facility	y JAMES A.	MORT	ON & SO	NS F.H., INC.
	80 E 8 9		James G	. no	ton		1701-31 I				RE, MAR	YLAND 21217
			23a. Part Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused one cause on each lin	the death. D	o not ent	er the mode of dyi	ng, such as	cardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Colonas a	Consequen	Rtt	ry Di	Seas	e			
	Examiner		Cognostially list appditions	Periph	oral	Va	scular	Dis	ase			
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75	be executed sicien end burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):									
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99	eath certificat attending phy I for use as the		IF FEMALE:	7								
Box	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth	2 Fetat dea	ath 3	Ectopic pregnancy	y			23d. Date of de	blivery Day Year
o	0 0 0	ysic	1 Yes 2 No	4☐Pregnant at 9☐ Unknown	time of death	1 5∟	Other (specify) _			_		
S,	The faw requires that the te has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions co	ontributing to death bu	t not resultin	g in the ur	nderlying cause giv	ven in Part I.	23e.	Did tobacco	use contribute t	to the cause of death?
Records,	w require been sign	ted	Hyperlipigemia	., km sta	ge ke	nali	Distase			1 ☐ Yes 2	□No 3□P	robably 4 Dunknown
Š	: The faw cate hes b	Completed	Decubitus U	icer Oai	Crum	1				Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical	Ff cyc					1 Y	es 2 No	death?	s 2□No
	ysician: is certific director,	8	examiner?	Hospital:	nt 2□ER/	Outpatien	t 3 DOA Oth	ner.	of Death Check or rsing Home 5 □ I	200 11 100	6 □Other (So	acutu)
n of		iio	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		b. Time of				ribe how inju		Soliyy
DIVISION	Attendi death. ctor: A y the fu	cath	2 Accident investigation 3 Suicide 6 Could not be				M 1	Yes 2 □ N				
2	if or Attenation after death Diractor:	Certification;	4 Homicide determined	28e. Place of Inju building, etc	ry - At nome, . <i>(Specify)</i>	, tarm, stre	eet, factory, office		City o	on (Street ar r Town, State	nd Number or H a)	lural Route Number,
			29a. Certifier 1 Certifying Phy	sicien: To the best o	f my knowled	dge, death	occurred at the tir	me, date and	d place, and due to	the cause(s) and manner a	s stated.
	To the H within 24 To the Fu complete	Medical	one) 2 Medical Exam	iner: On the basis of and manner star	examination	and/or inv	estigation, in my o	pinion, deat	n occurred at the ti	me, date and	d place, and du	e to the cause(s)
	S T W T S		29b. Signature and title of certifier	and 0.54			29c. Licens	se number	1,9,10	29d. Da	te signed (Mon	in, Day, Year)
	141	-	30. Name and address of person who c	ompleted cause of de	ath (Item 23	a) (Type.	Print)	00	4178	VIC	emptr	7,2001
	1"		James Tansi	rda M.	1 2	00.	1 cmnrv	PLAC	E, SuiTA	=3H		
	Stat		31. Date filed (Month, Day, Year)	-	r's Signature	Lo	and y	,	, 051	· · ·		
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Baltimore, Maryland 21215-0036	Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of front and wenter hyperic. Important: I fleen 21s and 21s and 21s and and and all and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at	
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		•	For State of Maryland / L State Registrar	Certificate of I			Reg. No.2 \bigcap \bigcap \bigcap	39564			
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death			
	/Medio Examin		Herbert Blake Jon 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cente	4b. City, Town, or	Location of Death		4c. County of Dea				
Ý.	Funeral	4	Social Security Number	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. Bir	thplace (State or Foreign			
D4	Director		244-16-2087 1♥ M 2□F 87 Usual Residence of Decedent	Yrs. Months Days	Hours Min.	(Month, Day March		orth Carolina			
	yland Iow at		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits			
	a-f sl	cto	Maryland Baltimore Lut	herville				1 □Yes 2X No			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any fiultry or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What C	ountry?			
	s 23a		6 Brooking Court, #201	21093	1	-it - V N-	USA 14. Race - Ame	orioon Indian			
	item item ner.n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ∑ Yes 2 No	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, Whi				
22	ursaf al",or Exa <u>m</u> i	ρ	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942–43	1 ☐ Yes 2 💢 No	Specify:		Specify:	hite			
ה ה	72 ho natur ilical i	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occup	during most of worki	ng	16b. Kind of Business				
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ō	lid be lental rked c	To Be	Henry Jones		Margue	rite	Corper	ning			
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. <u>`</u>	1 and 2. Health a em 27 is		Christine Jones/Daughter 5	00 Limerick	Cir. #10						
בַּ	Pages 1 nent of H int: If Itei iry or otl		I M Durial 2 [] Clemation 3 [] Removal from State	Disposition (Name of ry, crematory or other place	1 '		20c. Location - City of				
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ם ם	permit. Departri Importa any inju		Bryan W. Clary	Lemmon Fur 10 W. Pad	neral Home lonia Rd.	of Dul	laney Valle ium, MD 210	y, Inc.			
			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death			
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 1 Yes 2 No 9 1 Yes 3 No 9 1 Yes 4 Yes 4 Yes 5 Yes, outcome pf pregnancy 1 1 1 Yes 5 No 1 1 Yes 6 No 9 Yes 7 Yes, outcome pf pregnancy 1 1 Yes 6 Yes 7 Yes, outcome pf pregnancy 1 1 Yes 7 Yes 8 Yes 8 Yes 8 Yes 9 Yes 9							23d. Date of de Month	23d. Date of delivery Month Day Year			
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Ų,	ss that gned b	by Phys	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?			
, COLOS	require	ted				10	Yes 21No 3□F	Probably 4 ☐Unknown			
ב ב	e law I has be	Completed				24a. Was autoj	an 24b. Were a prior to death?	autopsy findings available completion of cause of			
g	n: Th ficate or, pag	ō Co	25. Was case referred to medical		00 Disease (Day 1)	1□ Yes	2 No 1 □ Ye				
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2	al or A s after il Direc	Certification:	4 Homicide determined building, etc. (Specify)	(Street and Number or Rural Route Number, own, State)							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one)								
	To th Within To th comp	Me	29b. Signature and title of certifier	29c. Licens	e number		29d. Date signed (Mor				
	1/1		grander & Ittella	m.O D41	1410	<i>1</i>	Scrember 1	22, 3001.			
	671		30. Name and address of person who completed cause of death (Item 23a) (ah da 1 han - ada barke e	CON :	(Amy) Akir	51 SQL			
	Sta	ite.	31. Date filed (Month, Day, Year). 32 Registrar's Signature	1 OSLER DE	TIVE TUW	SUN. P	HKYLHNU	II I III KIA			
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State Registrar

31. Date filed (Month, Day, Year)

W,MO 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Dr. SANDRA



BANKS, MD 7503 SURRATTS ROAD, CLINTON, MD 20735

29c. License number

D0062057

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARY S. KETCHUM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) HOSE Baltimore Good sementan tal N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Months Days Hours Min 1 □ M 2 K F 6/22/1918 MARYLAND 219-05-9872 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1812 GLEN RIDGE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KENNETH SPENCE SINCLAIR UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN F. KETCHUM/HUSBAND PARKVILLE, MD 21234 1812 GLEN RIDGE RD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/26/2007 ARLINGTON, VA ARLINGTON NATL. CEM. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23. Sent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) se Otic SLOCK Due to for as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? al renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 1☐ Yes 2 X No 26. Place of Death Check onl one

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

ural", or items 23a or 28a-f show Examiner must be notified at

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1 and 2 should be Health and M. ntal

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Funeral

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Completed

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Maryland 21215-0036

Baltimore,

burial-tra attending physician the page 2 funeral director. After this 24 hours after death.

Be (

Certification: To

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

filled in by

completely

within 24

Physician/Medical IF FEMALE 23b. Was decedent pregnant ð Completed

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samorton Kaspita / 5601 Fixth Roben Bla

State Registrar

31. Date filed (Month, Day, Year,

DEC 1 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nonth C FLLER 10 PM **Physician** ONALI 200 */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DSPITAL BAUTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 214-40-1296 Director Baltimore, Md March 18, 1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Funeral Director arkuill altmore 10g. Citizen of What Country? 10e. Street and Number or items 23a Hvenue Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Americen Indian, 11. Maritai Status Biack, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify þ 3 Widowed 4 Divorced whit 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cove if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keller H McGee Donald HANNA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkuille Marie Keller-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 11/2007 4 ☐ Donation 5 ☐ Other (Specify) 112/ Karkwood Cemeter 22. Name and Address of Facility

EVANS Funer Al Signature of Funeral Service Licensee + Cremation Services Funeral Chapel Harford Road Parkville md 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause at each line. Approximate Interval Between Ogset and Death Immediate Cause (Final dis Physician diseese or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗂 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death I Director: After the in by the funeral 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the for 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

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31. Date filed (Month, Day, Year)

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32: Registrar's Signature

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BATTADRE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 200 **Physician** 09 Socimbes HEDWIG Η. KOSAR /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Hone Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🗙 F Hours Director 164-22-5787 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director LUZERNE EXETER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 1 TROBACK DR 18643 UNITED STATES

14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Baltimore, Maryland 21215-003 3 Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERK GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 CHARLES KASULEN MARY (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN KOSAR / NEPHEW 51 PULASKI ST. HANOVER TWP., PA18706 20b. Place of Disposition (Name of cemetery crematory or other place)
ST. PETER &
ST. PAUL CEMETERY Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DECEMBER 12, 2007 PLYMOUTH, PENNSYLVANIA 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21. Signatur # Funeral Service Licenses 421 CRAIN HWY. SE; GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final STroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of light of the tribute of the cause of light of the tribute of the cause of the caus Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the functeral director, page 2 should be detached for use as the burial-transit completely filled in by the functeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform 2 X No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2**2** N₀ 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti Mos 1063726 82041 Q30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DELODAMM

31. Date filed (Month, Day, Year) 2007

DHMH 17 Rev 1/2001

10015

meren

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EARI) AMES 200 DECEMBER /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEZ BURNIE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
July 24, 1 Birthplace (State or Foreign Country)
TN 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days **1** M 2□ F 410/44/1955 1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 1730 Leisure Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 KKes 2 No If Yes, Give 48-74 Year or Dates: 1 ☐ Never Married > Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ XNo Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) Police Officer Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keeling ဥ James Cory Cole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other tr once. Mrs. Erna A. Keeling (wife) 1730 Leisure Lane Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial XXI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 12/10/07 Stevensville, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility SINGLETON FUNERAL&CREMATION SERV. 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR FIRMICATION 12 HOURS /Medical Due to (or as a consequence of) Examiner COROUPRY ARTERY
Due to (or as a consequence of): 20 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed CHRONIC RENAL PAIWAE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy perform certificate 2 No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending To the noop after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospital 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Chippuns). Grandiers 40 41823000

State

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUICLERNO DOSÉ CIANGRECO 301 HOSPITAL DRIVE, GLEH BURNIE, HD 20161

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item at the of Mass and Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 8, 2007 **Physician** 11:28 P M Raymond W. Klecker, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Brighton Gardens Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Brig (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X** M 2□ F Director 87 Sept. 20, 1920 Wisconsin 391-16-6360 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than mat the Medical Examiner must be notifiled at any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2X No Directo Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9503 Hollins Court 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Olive Dolliver William Joseph Klecker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette A. Klecker/Wife 9503 Hollins Court, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December Silver Spring, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12, 2007 Gate of Heaven 4 □ Donation 5 🕅 Other (Specify) Entombment 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licenses M01346 Bethesda, Maryland 20814 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Cardiomyopathy and resulting in death) Last Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1□ Yes 2X No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Living Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🔀 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 😋 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State

6320 Depocracy Blvd. Bethesda, MD 20817

31. Date filed (Month, Day, Year) DEC 1 1 Registrar

Ajay Reddy,

29b. Signature and title of certifier

32. Angistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D53691

December 10, 2007

Physician /Medical Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

	1 - For State Registrar	olato ol Marylan		tificate of		a workar rry	Reg. No. 2	007	3957		
an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1/2:4										
al er	4a. Facility Name (If not institution, give s Keswick Multicare	street and number)		4b. City, Town, or Location of Death Baltimore			4c. County		12.40		
	Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	in. (Month, Da	th y, Year) 26, 1925	Coui	place (State or Foreign ntry) rland		
	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	eation				1	10d. Inside City Limits		
tor	Maryland N/A	Ba	altimor	ore					1x Yes 2 □ No		
Be Completed by Funeral Director	10e. Street and Number 700 W. 40th Street			10f. Zip Code 10g. Ci					ıtry?		
uner	Tr. Maritar Otalao	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto			ecify Yes or No- Rican, etc.) 14. Race - Al Black, W				
d by F	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 ☐ Yes ♣★No If Yes, Give Year or Dates:		☐ Yes XX No				ite			
plete	15. Decedent's Edu (Specify only highest grade	e completed)	(Give k	kind of work done ONOT use retired	during most of	16b. Kind of Business/Industry					
Som Som	Elementary/Secondary (0-12)	College (1-4or 5+)	Н		Own Home						
To Be (17. Father's Name (First, Middle, Last) Peter Mc Entee		_			Name (First, Middle, e Stewart		ne)			
ľ	19a. Informant's Name/Relationship (Ty) Richard Linardi	rpe. Print) Son		b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4412 Falls Road, Baltimore, Maryland 21211							
	20a. Method of Disposition					Date	20c. Location				
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 20c. L								ım, Maryland		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition resulting in death)	Atheroschustie cardiovasenlar disease							Inset and Death		
		Due to (or as a conseq									
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of).									
xam	that initiated events resulting in death) Last	Due to (or as a consequence of):									
calE		.d									
Medi	IF FEMALE:						1	- 1			
ician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3□	Ectopic pregnance Other (specify)	у	23d. Date of delivery Month Day Year					
hys	9 □ Unknown		23e. Did tobacco use contribute to the cause of death?								
Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 Pro 3 P										
plet	24a. Was an autopsy prior to comp										
o Be	25. Was case referred to medical examiner? 1 Ves 2 Ves										
tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 Yes 2 No						7/		
Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Rural Ro						al Route Number,			
dical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier			29c. License number 29d. Date signed (Month, Da							
	Dr. Tapbelle Tax	- Gregor h	D	2/30		December 11, 2007					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NFIBELLE THE REGOR, 700 W. 40 th Street, Balthure, nd 21211

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year December 5, 2007 **Physician** 1552 Marie E. Lockard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 14120 Hanover Pike Reisterstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 25, 1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 M X X X Maryland 219-10-3442 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 🏋 📉 No Reisterstown Baltimore **Funeral Director** MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number "natural", or Items 23a or U.S.A. 21136 14120 Hanover Pike 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Black, White, etc. 1 ☐ Never Married XX Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natui any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Moser Raymond Bean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband 14120 Hanover Pike, Reisterstown, MD 21136 William Francis Lockard / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Inc. 12/06/07 Baltimore, MD 4 □ Donation 5 □ Øther (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Furiera Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ma **Physician** 1161011 disease or condition resulting in death) /Medical Due to r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as ase. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 2 10 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perforn 1□ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 2 ☐ ER/Outpatient 3 ☐ DOA 5,2 Residence 6 Dother (Specify) 1 🔲 Inpatient Certification: To 1 ☐ Yes this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Iniury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Business Cente Drive han onc 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 1 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:05PM **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HolvenTist Montgomery IAKOMA Park ASHINGTON HOSPITAL MO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗹 F 122 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No Director ASHINETON DC 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 VIIII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ NO Specify: Black Specify: Maryland 21215-0036 þ 3₽Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOTUSE retired)

FOCA SERVICE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jones GUWNN Jessie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WhitNE Baltimore, Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 12/8/07 andover, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Lice complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Pike - Forestuille, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Du to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner o venous certificate be executed and a consequence of) physician at s the burial-t Box 68760 Physician/Medical as h signed by the attending r IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate has 2 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 No ည To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed, (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar DFC 1 1 2

31. Date filed (Month, Day, Year)

ChirumAmilla, M.D.

Day, Year)

325 Registrar's Signature

C. 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1600 CARROLL AVENUE TOKOMA Park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 39574

Regin	ald Weldon	1-1	For State	tate of Maryland	/ Departm Certific	nent of cate of	Health an Death	d Menta	l Hygiene	Reg. No.		3. Time of	3957 Death
	Physician		Decedent's Name (First, Midd	dle,Last)					Month	Day mber 8, 2	Year 007	2215	1
Me	Examin	er	Reginald weld				b. City, Town, or	Location of		4	c. County of De	ath	
		48	. Facility Name (if not instituti 295 South & 32	on, give street and number	.)	1	Fort Mea				Anne Arund		
				6. Sex 7. A	ge (In yrs. last b	oirthday)	If Under 1 Yes	ar If Under	24Hrs. 8. Dat	e of Birth(MN	1/DD/YYYY) 9.	Birthplace (Sta reign	ate or
	Funeral	5.	Social Security Number 107–68–9179		35	Yrs	Months Day	ys Hours	Min. Aug	g. 6, 19		Country) NY	
	Director			1 M 2 F		113.	1					Tro Lively	t- City Limits
	any		sual Residence of Decedent Da. State 10b. Count	у	10c. City, To	wn or Locati			_				de City Limits
	_ & al			ice George									
	ryland a-f sh	휭	0e. Street and Number				10f. Zip Code	6710		10g. C	itizen of What (Country?	
	or 28	Director	3801 Kenilwort	th Avenue				6710				merican Indiar	n Black
	with the is 23a	E 1	1. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13. Wa	as Decedent of H	lispanic Origi an, Mexican,	n? (Specify Ye Puerto Rican,	es or No- etc.)	White, e		I, Diaon,
	eath ritem	Funeral	Never Married 2	1 Yes	2 X No	1	Yes 2 x				African	America	m
	after c	Ð.		Divorced If Yes, Give Year or Dates:	lated) 1	Ca Docado	nt'e Usual Occur	nation (Give k	and of work do	ne 16t	. Kind of Busin	ess/Industry	
	natur	g	15. Decedent's Education (S			during f	nost of working li	fe. DO NOT	use retired)				
	16 n 72 l nan ", ical l	Bet	Elementary/Secondary (0-1	4	5. 5 /	tead	cher			scl	nool syst	.em	
	with giene her the	Completed	17. Father's Name (First, Mide	dle, Last)				18.Mother	s Name (First,				
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Regi	nald W. Lewis,	Sr.		ng Address (St		Jani	ce L. E	City or Town	State, Zip Coo	de)
	212 ould b Men mark	2	19a. Informant's Name/Relati									,	
	MD d 2 sho lth and n 27 is aumat			ewis, Sr. / Fat	her	ace of Dispo	Great Pine	cemetery,	Date	2	Oc. Location - C	ity or Town, S	tate
	_ a = _		20a. Method of Disposition 1 X Burial 2 Crema	ation 3 Removal from	State cr	ematory or	other place)		10/15/00	207	empstead.	Norr Vot	rlr
	Page:		4 Donation 5 Other	r Specify:	Gree		Cemetery Name and Add	ess of Facilit	12/15/20				LK
	Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Sen			16	28 N Cil	mor Str	oot • Ra1t	imore.	Marvland	21217	
		$ldsymbol{\sqcup}$	23a. Part I. Enter the disease	e or complications that cau	sed the death.	Do not ente	r the mode of dy	ing, such as	cardiac or resp	iratory arrest	, shock, or hear	t Appro	oximate Interval veen Onset and
1	`hysician ∦edical		failure. List only one ca	iuse on each line.									Death
	∠xamine		Immediate Cause (Final dise or condition resulting in deal):							
			Sequentially list conditions,	b									
		ner	if any, leading to immediate	ause	consequence of	}:							
		Examine	(Disease or injury that initial events resulting in death)	ted	consequence of):							
	be executed ician and inial - transit	l m		d									
	e exercian a	dical	UNPENDED	AMENDED							23d. Date of	delivery	
	Box 68760, e death certificate be the attending physic and for use as the burn	Physician/Me	IF FEMALE: 23b. Was decedent pregnan		utcome of pregr	nancy 2	Fetal death	3 Ecto	pic pregnancy		Month	Day	Year
	68 certifi	cian	past 12 months?		ant at time of de		Other (Specify)					
	30X death	ıysi	1 Yes 2 No 9	Unknown 9 Unkno				uno given in	Part I	23e. Did tob	acco use contr	ibute to the ca	use of death?
	ires that the dea	P P	Part II. Other significant c	onditions contributing to	death but not r	esulting in t	ne underlying co	idae givoiriii		1 Yes	2 ✔ No 3	Probably	4 Unknown
	ires th	Aq pa								24a. Was a		Were autopsy	findings available etion of cause of
	ords, v requir									autops perfor	ned?	death?	
	eco he lav ate ha:	۶ I ۲			_				il (O) Il all	1 ✓ Yes 2	No 1	✓ Yes	2 No
	m: T	Be C						Other	ath (Check only Nursing H		Residence 6	✓ Other: Sce	ne
	Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been signed.	funeral director, page	1 ✓ Yes 2 N	0	Inpatient 2	ER/Outpa		c. Injury at W	lork2 28	d Describe t	ow injury occur	rred	
	of ing Pt After	unera		28a. Date	Day,Year)	FOUND):	1 Yes 2	1Dr	iver auto 1	ixed object	collision	
	tend teath.	y the 1	1 Natural 5	Teliumy Doo o	2007	2201 hr home, farm,	street, factory, o	office building	, etc. 28	f. Location (Street and Num	ber or Rural R	oute Number, City
	ivis lor A after Dires	filled in by the fune	3 Suicide 6	determined (Specify)	Interstate	/Express			29		tate) 32, Fort Mead		
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and	ille S						ime, date and	d place, and du	ue to the caus	e(s) and mann	er as stated.	uno(n)
	the Ho in 24 the Fu	pletel	(Check anly ane). 2 Medic	al Examiner: On the basis	of examination	and/or inve	stigation, in my	opinion, deat	h occurred at th	he time, date			Ony Year)
1	Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	completely	29b. Signature and title of	and mainte	States.		29c.	License num	ber		290. Date sig	gried (Months, s	vay, i cai j
			Wellens	- (1)	full			O.C.M.E.			Decembe	3, 2007	
	0		30. Name and address of	person who completed car	use of death (Ite	em 23a)		. D. III	oro MD or	1201			
	.		Margarita Korell	MD. Assistant Me	edical Exam	iner 1	11 Penn Stre	eet, Baltim	IOIE, IVID 2	1201			
		Sta),	Registrar's Signa	ature	K)						
	Re	gistr	DEC11	2007	aring find	1	3.7					OCME	

ORIGINAL

Physician /Medical Examiner

be executed

show at

28a-f

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must.

Baltimore, Maryland 21215-0036

DECEMBER

with 23a or 8

notified

burial-transit attending physician for use as the buria ed by the a detached f

P.O. Box 68760, Ca Attending Physician: The law requires that the death certificate Division or Vital Records, director, this funeral After t death. after death ō Hospital 24 hours a

MARTIN,

Completed Be 2

ate has been signed by page 2 should be detacl filled in by the

To the within 2

State Registrar

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 28 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year) 1 2007 32. Registrar's Signature

29b. Signature and title of certifier

and manner stated.

2300 DULANEY VALLEY ROAD

29c. License number

TIMONIUM MD

29d. Date signed (Month, Day, Year)

21093

			1 - For Stete Registrar	State of Maryland	/ Department		Mental Hygien	2001 00010
I	Physici /Medic		1. Decedent's Name (First, Middle, L		arreil		2. Date of Death Month Da	y Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, T	own, or Location of Deal	th 40	C. County of Death
	Funeral Director		5. Social Security Number 6. 228-36-6532	Sex 7. Age (In yrs. las	Yrs. If Under Months			9. Birthplace (State or Foreign Country)
	ehow	5	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits 1 1 → es 2 □ No
	death with the Maryland ma 23a or 28a-f ehow rinust be positied at	Directo	10e. Street and Number	A	13 A/T;		10g. C	itizen of What Country?
9	hours after death with the Marylan lural; or flema 23a or 28a-f ehow al Examiner ment te notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give	13. Was Decede If Yes, speci	ent of Hispanic Origin? (S ty Cuban, Mexican, Puer No Specity:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
00-612	hin 72 hour e. en "neturel" Medicel Ex	pleted b	3 Widowed 4 Divorced 15. Decedent's B (Specify only highest g Elementary/Secondary (0-12)	Hear or Dates:	16a. Decedent's Usual (Give kind of work life. DO NOT use	k done during most of wo	orking 16b. E	Cind of Business/Industry
IZ bui	be filed wit tat Hygiened of other the	Be Completed	17. Father's Name (First, Middle, Las	2 VRS	SA/es		me (First, Middle, Maide	n Sumame)
Maryla	nd 2 should lith and Mer 27 is marker r traumatic	<u>유</u>	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address	(Street and Number of	ural Route Number, City	or Town, State, Zip Code)
more,	Pages 1 are of Healent		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	ce of Disposition (Nametery, crematory or other	e of her place)	Date 20c. L	ocation - City or Town, State -ORT SMITH. VIA.
Balti	Departm Departm Importar any Injur		21 Signature of Funeral Service Lice		22. Nam and	Address of Facility	ensin 15, 20	100 212/3 1-BAITO, MI)
	Physician		23a. The Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. y one cause on each line.	Do not enter the mode	of dying, such as cardia	c or respiratory arrest, with Med	Approximate Interval Between Onset and Death
	/Medical Examiner	16		b Due to (or as a consequent	nce of):	olifera.	tive Disc	ider yes
, ,	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. HURTEN Duglo (or as a conseque	NSION nce of):		***	yrs
200	he he	Aedical	ecoure.	. Diabet	es yep	e II		YRS
.C. BOX	the death certific y tha attending pl ached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal do 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pre			23d. Date of delivery Month Day Year
oras, r	law requires that the death as been signed by tha atter 2 should be detached for u		Part II. Other significant conditions NISTORY Def MI	contributing to death but not resulting to more than the contribution of the contribut	ing in the underlying ca	use given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 □No 3 □ Probably 4 ☑ Jinknown
	The ate h page	Completed by	Thrombosis				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
=	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	PVOutpatient 3 □ DO/	Othor	ath (Check only one)	• To: 40 / 1
	a Phys er this eral dii	n: To	27. Manner of Death			tc. Injury at Work?	28d. Describe how inju	6 ☐ Other (Specify) ury occurred
5	Attending Fir death. • ctor: After by the funer	atlo	Pending 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No		
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	Certification;	3 Suicide 6 Could not	building, etc. (Specify)			City or Town, Stat	
	the Hosp hin 24 hou the Fune mpletaly fil	Medical	one) 2 Medical Exa	hysicien: To the best of my knowle miner: On the basis of examination and manner stated.	n and/or investigation,	in my opinion, death occi	urred at the time, date an	nd place, and due to the cause(s)
	wil To		29b. Signature and title of certifier	Reilly	.44 /1	License number 5474		elck, Md Z1701
	(11)	ta	30. Name and address of person who said the said said	gompleted cause of death (Item 2 4 MN) 801 7 32. Registrar's Signatur		e Ave, D-	, Frence	rick, Md 21701
	Sta Registr		DEC 1 1	2007	K Brails	p		

			1 - For State Registrar	State of Mary	land / Depa		Health and M	lental Hy	_	07 3957	7
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath	3. Time of Death	h
	Physicia /Medic		Christine	Alma	M	iller		Month Decembe	er 8,200	7 11:00	A^{M}
	Examin	_	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County		
		ш	1011 Lilac Lane			Glen Bu	rnie		Anne A	Arundel	
	Funeral		Social Security Number 6. S	ex 7. Age (lin ☐ M 2 文 F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplace (State or Fore Country)	əign
#. }-	Director	2	219-22-21/8	LW ZX	88 Yrs.			March	13,1919	TN	
7	3		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Lim	nits
Apple	f sho	ō	MD Anne Ar	undel (len Burn	io				1 □ Yes 2 🔀	No
4	28a- notif	Director	10e. Street and Number	ander (Jen Barn	10f. Zip Code			10g. Citizen of V	What Country?	
unit.	3a or it be	Ö	1011 Lilac Lane			21061			U.S.A.		
****	ms 2	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.		Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or No		ce - American Indian,	
(0	r iter	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No				Rican, etc.)		ck, White, etc.	
5-0036	ral", c	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🗓 No	Specify:		Specify	y: White	
2-0	natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occu	during most of work	ina	16b. Kind of B	usiness/Industry	
21215-0036	ne. nan "	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	(d)				
2 4	her th		1 Z		Meat	Packer	18. Mother's Nam	o /Eirot Middle	Groce		
and	ntal F	B	17. Father's Name (First, Middle, Last)							ne)	
2	d Me nark natic	ဥ	UNKNOWN 19a, Informant's Name/Relationship (Tuno Print)	19b Maili	na Addrage (Strag	Bessie	Queene		State Zin Code)	
Maryland	Theath and Mental Hygiene. The training the state of the		Mrs. Pamela D. Wh				ine Glen E				
ئ ئ	Heal tem 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			Date		- City or Town, State	
Ou	t: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐	nemoval from State			, Dec.	12,	01 n	MD	
Baltimore,	artme ortan Injur		4 □ Donation 5 ⚠ Other (Specify 21. Signature of Funeral Service Licer						Funoral	rnie, MD & Cremation	
Ba	Department of Health a Important: If item 27 is any Injury or other training.		make		Se	ervicesl	2nd Avenu	ie SW G1	en Burn	ie, MD 21061	
	- 21		23a. Part 1. Enter the disease, or com	plications that caused the	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between	
ь	hysician		shock, or heart failure. List only Immediate Cause (Final		0	enal Di				Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a co		eval Di	ડ્લમ				
E	xaminer			h							
17		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):						
1	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
760, A	sician and burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):						
6876	physician the buria	dical		d							
× 5	attending physic	Physician/Medi	IF FEMALE:	220 If you outcome of r	roananov					1-	
Box	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnanc	у			ate of delivery onth Day Year	
o g	the shed	ysic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9☐Unknown	e or dearn 5	Other (specify)_					
Records, P.O. Box 687	signed by the a		Part II. Other significant conditions of	ontributing to death but ne	ot resulting in the u	inderlying cause gi	ven in Part I.	23e. Did t	obacco use con	tribute to the cause of death	?
Records,	sign Id be	d by						10	Yes 2 No	3 Probably 4 Unkno	own
COL	been s	Completed						24a, Was	an 24h	Were autopsy findings availa	able
E E	has ge 2	du						auto	psy ormed?	prior to completion of cause death?	of
			25. Was case referred to medical				26. Place of Deat	1□ Yes	-,,	1 ☐ Yes 2 ☐ No	
or Vital	is certificate hadirector, page	o Be	examiner? 1 \(\sum \text{Yes} 2 \overline{\overl	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Ot	hor:		dence 6 □Oth	har (Sacrify)	
O	h. After this funeral d	7: To	27. Manner of Death	28a. Date of Injury	28b. Time o			-	how injury occur		
Division	h. r After funer	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury		rk?]Yes 2 □No				
Vivision or Vita	ectol ectol by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (8		reet, factory, office		28f. Location (ber or Rural Route Number,	
	s after	Certification:	4 [] Torricide	building, etc. (c	эреспу)			Ony or ro	wii, State)		
penin	hour unera			ysician: To the best of m							
d H	in 24 the Fi	Medical	one)	and manner stated				ried at the time,	uate and place,	and due to the cause(s)	
Ę	within 24 hours after death. To the Funeral Director Aft completely filled in by the fur	Σ	29b. Signature and title of certifier				se number		29d. Date signe	ed (Month, Day, Year)	
	/		Int	>			050108		כן	1/10/2007	
	ウ		30. Name and address of person who				,			_	
			31. Date filed (Month, Day, Year)	32. Falistrar's		d, Sv. L	200 6-1.	en Burn	M, MO	21061	
	Sta	ite	TEC 1 1	oz. majistrar s	oignature	A					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

brielle Martin		1- For State	ate of Maryl		artment of rtificate of		and	Menta	ıl Hyg			07	3957
Physici		Registrar 1. Decedent's Name (First, Midd	e,Last)							. Date of Death		3. Tin	ne of Death
dical Exami	ner	Cabriell	e Quantin	a Marti	n					Month December	Day Year 3. 2007	14	30 hrs
		4a. Facility Name (if not institution				c. City, Tov	n, or Lo	cation of [4c. County of D	eath	
		Johns Hopkins Hospit	al			Baltimo	re				N/A		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under 2		8. Date of Birth	(MM/DD/YYYY) 9		(State or
Director		426-61-4107	1 M 2 XF	19	Yrs.	Months	Days	Hours	Min.	12-27-	L987	oreign Country)	MS
		Usual Residence of Decedent											
/ any		10a. State 10b. County		10c. City	, Town or Location	n					-		nside City Limits
and show	ក	VA		Vir	ginia Be	each						1 X	Yes 2 No
Aaryl 28a-f	Director	10e. Street and Number				10f. Zip Co	ode	•		10	g. Citizen of What	Country?	
death with the Maryland or items 23a or 28a-f show must be notified at once.	ä	3804 Caribou C	ourt			2345	66			l 1	J.S.A.		
ms 23	eral	11. Marital Status	12. Was De	cedent Ever in U		Decedent	of Hispa			cify Yes or No-	14. Race - A		dian, Black,
death or ite must	Funeral	1 X Never Married 2 M	arried Armed F	2 X No	II Ye	s, specify (Juban, N	nexican, P	uerto Ri	ican, etc.)	White, e	tc.	
after al",	by		orced If Yes, Give Ye or Dates:			Yes 2 X		_		30.00	Specify: B	lack	==
hours	ed	15. Decedent's Education (Spe			16a. Decedent during mo	s Usual Oc st of workin					16b. Kind of Busin	ess/Industr	y
36 in 72	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)			5			,			
with with her the	Completed	12 17. Father's Name (First, Middle.	1+>		Stud	ent	140	Madeada	Name (Time Adiabata N			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		Terrance Deoi	•								laiden Surname)		
212 ould be Menta mark c even	o Be	19a. Informant's Name/Relations			19b Mailing	Address					te Martin ber, City or Town, S		ode)
, MD 21215-0036 eard 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	-	Terrance D. Smi		ner							Beach, V	-	· .
and and Health		20a. Method of Disposition		20b.	Place of Disposit	ion (Name				Date	20c. Location - Ci		
JOT ages l nt of l t: If		1 XBurial 2 Cremation		om otate	crematory or oth lonial G		Mom	D1- 1	12_0	2007	Virginia	Dage	L 57.A
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner mu		4 Donation 5 Other St. 21. Signature of Funeral Service	pecify:	100.							0		11, VA
Ba Depz Imp	Į	Cort AV	1		Mi	tchel	1-W	iedef	eld	Funera	1 Home,	Inc.	212
Physician		23a. Part I. Enter the disease, or failure. List only one cause	compli ations that	caused the death	Do not enter the	e mode of a	lying, su	ich as card	diac or r	espiratory arre	st, shock, or heart	App	roximate Interval
/Medical	- [on each line.	ootions of	e en cond	:a1 a4-						Bet	ween Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of	rericard	iai sti	ICLU	re				$\overline{}$	
		Sequentially list conditions,	b Compli	ications o	f adriany	cin car	diot	oxcity					
	Ĭ.	if any, leading to immediate cause. Enter Underlying Cause		a consequence of			4						
#	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	cute myel	enous	s teu	kema					3
o, e be executed ysician and burial - transit	9		d										
0, e be exe ysician a burial -	edical	XUNPENDED	#MENDED	ne a-c 27	, perME,g	27/ ₁ 1′	7/27/	יידי לה'					
760 cate b	Me	IF FEMALE:	Z3C. If yes,	outcome of preg	nancy	J/4, 12	_//	0/ 11			23d. Date of de	livery	
Box 6876(the death certificate the attending physele for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	ı 🗀 rıve	birth nant at time of de	noth	al death	3	Ectopic p	regnand	су	Month	Day	Year
Sox leath e atter for u	sic	1 Yes 2 No 9 Uni	known g Unkr		5 Oth	er (Specify)						
D. E. It the o		Part II. Other significant condit			esulting in the ur	iderlying ca	use giv	en in Part	1.	23e. Did to	pacco use contribu	te to the ca	use of death?
ords, P.O. Iw requires that the as been signed by the should be detached.	ğ									1 Yes	2 🗸 No 3	Probably	4 Unknown
ds, requir	ete		·							24a. Was a			findings available
Records, The law requir ficate has been s	Completed								_	autops perfor	med? dea	th?	tion of cause of
Re ifficat or, pag		25. Was case referred to medica				26	Diago o	f Death (C	hook on	1 Yes 2	No 1 •	Yes	2 No
ing Physiciau: The law After this certificate has uneral director, page 2 si	a	examiner?	Hospital:	Inpatient 2	ER/Outpatient		In	her -			Residence 6	Other:	
J of V Jing Phy After th funeral of	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of In			at Work?			ow injury occurred		
ion c tending eath. lor: Af the fun	ertification:	1 X Natural 5 Pend	(Mont	h, Day,Year)		1	Ye	s 2 N	- 1				
Division tal or Attendius after death.	Ë		stigation 28e. Plac	ce of Injury - At h	ome, farm, street	, factory, of	fice buil	Iding, etc.	2	8f. Location (S	treet and Number	or Rural Ro	ute Number, City
Divinal or ours after Dir filled in	핗		d not be mined (Specify,)						or Town, St	ate)		
Hosp 24 ho Fune etely fi	a	202 Certifier	nysician: To the be	st of my knowled	ge, death occurr	ed at the tir	ne, date	and place	e, and d	ue to the cause	e(s) and manner as	stated.	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Atlending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		miner: On the basis and manner:		and/or investigation				rred at t	he time, date a	and place, and due	to the caus	se(s)
1 7 2 3	Ž	29b. Signature and title of certifie	er				icense r				29d. Date signed		ay, Year)
		tamete Poucher	U, MA				D.C.M	.E.			December 4,	2007	
-0-	İ	30. Name and address of person									-		
		Pamela E. Southall, M	ID Assistant	Medical Exa	miner 111	Penn S	treet,	Baltimo	re, M	21201			

Registrar DHMH 17 Rev 1/2001 OCME 2006

				epartment of Health and Mental Hy	giene
				Certificate of Death	Reg. No. 2007 39579
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
L.	/Medic		Dominic P. Miller 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	er 6, 2007 9:22PM M
	Examir	er	Carroll Hospital Center	Westminster	Carroll
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		th 9. Birthplace (State or Foreign
i.	Director		213-04-0020 40		1, 1967 MD
	and t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Mary I-f she fied a	to	MD Carroll Ha	mpstead	1 ☐ Yes 2 🗖 No
4	th the or 28s e notii	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1	ath wi	ral	400 Lees Mill Road	21074	USA
	er de: items ner m	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	o- 14. Race - American Indian, Black, White, etc.
36	ırs aft al'', or xami	by F	1 √√ Never Married 2 □ Married 1 □ Yes 2 √√ No If Yes, Give X 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
21215-0036	/2 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed		Decedent's Usual Occupation	16b. Kind of Business/Industry
21	ithin / ne. nan "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working life. DO NOT use retired)	
72	Hygier Hygier Her th	ပ္ပိ	12 17. Father's Name (First, Middle, Last)	Service Tech 18. Mother's Name (First, Middle	Copiers
Maryland	d be t antal l red of) Be	Earl W. Miller, Jr.	Linda L.	,
ary	shoul nd Me mark	은		Mailing Address (Street and Number or Rural Route Numb	
ž į	ss 1 and 2 of Health a item 27 is other trau			Lees Mill Road, Hampstead	
Baltimore,	Fages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. aft. I flem 27 is marked other than "natural", or items 23a or 28a-f show ant; I flem 27 is marked other than "natural", or items 2 be notified at ury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of I cemetery.	Disposition (Name of Crematory or other place)	20c. Location - City or Town, State
E E	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Carrol1	Cremation 12/7/07	Hampstead, MD
Bal	Depar Depar Impor any in		21. Signature of Funeral Service Licensee		Reisterstown Road
			23a. Part1. Enter the disease, or complications that caused the death. Do not	Eline Funeral Home Reist	
P	hysician		snock, or neart tailure. List only one cause on each line.	GSW	Onset and Death
1	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of		500nd9
E	Examiner		Sequentially list conditions b.		
700	ed sit	ine	Sequentially list conditions, if any, leading to immediate cauce. Either U.d.ryhing Cause (Disease or injury):	
4	al-tran	Examiner	that initiated events resulting in death) Last):	
8760,	ate be executed hysician and the burial-transit	ical E	d		
89	as th				
Box 6	attending ph	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	3 □Ectopic pregnancy	23d. Date of delivery
O 2	the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)	Month Day Year
O. 4	ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
Vital Records,	n sign	d by		1 🗆	Yes 2☑No 3☐ Probably 4☐Unknown
000	s bee	Completed		24a. Was	
<u> </u>	After this certificate has funeral director, page 2	mo		auto perfc 1	ormed? death?
/ita	ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of	
Or	this c	၉		atient 3 DOA Other: 4 Nursing Home 5 Resi	
Division or	After funer	ij	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury	ury Work?	how injury occurred
VISI	r deat ector;	flca	3 Suicide 6 Could not be 28e. Place of injury - At home, farm	n, street, factory, office 28f. Location (3	Street and Number or Rural Route Number,
	al Dir	Certification:	Dullding, etc. (Specify)	owl 400 Le	res Will Road Hompstand
Hospi	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier (Check only 2 — Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and due to the	cause(s) and manner as stated
the	thin 2 the mplet	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number	29d. Date signed (Month, Day, Year)
ا ا	. ≱ ¥ 8		1.7 (1.12.4.0)	0	
	0	-	30, Name and address of person who completed cause of death (Item 23a) (To		December 07, 2007
	Ψ		Herbert P. Henderson Jc. M.D. 2a	73 Manchester RJ Manch	1844 MD210)
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A. N.	
	Registr	al .	TITO I I TOO TOO YES	JAJANES J	

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 062007 Hattie Paylor 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Ballimore 3al himore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Yrs 237-64-9497 27 42 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y□Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3344 Avondale Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No Specify: Black 3 ☐ Widowed ★☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Acme Packing Co. Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert J. McAuthur Vertie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Relationship (Type. Print) Fannie Yvonne Paylor-Daughter 1108 North Stricker Street, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) King Memorial Park 12/11/07 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility anno March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final ease or condition resuring in death) 3 days 0513 Due to (or as consequence of): Oiverbalih's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pendina investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and for use as the hurial-transfer or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the a been signed by should be detack funeral director this After 1 s after death filled in by within 24 hours a To the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 1 1 2007

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked ofher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

tie

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YASSAR YOUSSEF H.O.

32, Registrar's Signature

JASSAR YOUSIEF M.D. Sinai Hospital & Baltinone

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Voar 025AM Karker **Physician** 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Mora If It Examiner 325 Anoka If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Min Hours Months 10M 20 F Director 213-82-1105 -10-1925 Yar Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State ?7 is marked other then "naturel", or flems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 →Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other then "naturei", or ttems 23s or? 21215 2325 1402 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ho
If Yes, Give
Year or Dates: Black, White, etc. 1 Linever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health an important: if item 27 is eny injury or other trau Anoka 2325 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State + Crematery 4 □ Donation 5 □ Other (Specify) (STREETHOUR Dacility 21. Signature of Funeral Septice Licensee He willow Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lige. Immediate Cause (Final Stain Tumous **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) with hypotenerion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examine the attending physicien and hed for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should t Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No : After this certifical funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home P 1 ☐ Yes 2 PNo 1 Inpatient 2 ☐ EB/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Af

the

State Registrar

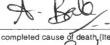
Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Amaba 19 vahan 31. Date filed (Month, Day, Year)
DEC 1 1 2007



**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

asuBR 13a Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.7

			For State Registrar	State of Mar	yianu / i	Ceri	tificate of	neaith and Death	Meni		g. No.	U /	39583
Ü	a de la coloi	20	Decedent's Name (First, Middle, La	st)			·			ate of Death		Year	3. Time of Death
	Physici /Medio		Jerry Henry	Pender			45 Ott. Town	- l tion - of Doo	Dec	ember	9 2	007	2:18 a ^M
	Examin	er	4a. Facility Name (If not institution, giv 2440 McCulloh Sti				4b. City, Town, o Baltim		itn		4c. County		
	Funeral Director		5. Social Security Number 6. S 218-44-2015	7. Age ('In yrs. last bii 54	rthday)_ Yrs.	If Under 1 Year Months Days		s. 8. D	ate of Birth Month, Day, EP 17		9. Birth	place (State or Foreign ntry) yland
	fand ow it		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Tow	n or Loc	ation						10d. Inside City Limits
	a-f she	ctor	MD N/A		Balt	imor	e						1. Yes 2 No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 2440 McCulloh Sti	reet			10f. Zip Code 21217			10	lg. Citizen of	What Cou USA	ntry?
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates:	er in U.S.		/as Decedent of H Yes, specify Cube □ Yes 2 🖾 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify \ orto Rican	es or No- l, etc.)		ck, White,	can Indian, etc. ack
2-0	"natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	. Decede	ent's Usual Occup ind of work done O NOT use retired	oation during most of we	orking	1	6b. Kind of B	usiness/Ir	ndustry
212	l within liene. r than the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Ma	anag		<i>2)</i>			Hospi	tali	ty
Maryland 21215-0036	S T S	To Be C	17. Father's Name (First, Middle, Last Walter Pender)				18. Mother's Na Betsy		t, Middle, M ender	laiden Surnar	ne)	
ary	a 6 9 10	-	19a. Informant's Name/Relationship				Address (Street						'
	1 and 2 Health em 27 other tr		Vivian Pender -	wife			McCulloh		, Bal		e, MD	212	
mor	Pages ent of l nt: If ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specie				ition (Name of atory or other place matory,			-		•	•
Baltimore,	permit. Pages 1 Department of I Important: If Ite any Injury or ot		21. Signature of Funeral Service Lice			22.	Name and Addre Crematio 299 Fred	ss of Facility et	ty of	f Mary	land,	Inc.	21228
_	193		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do								Approximate Interval Between
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_	certific iding p		IF FEMALE:	23c. If yes, outcome pf	pregnancy						22d D	te of deliv	(op/
P.O. Box	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 4 ☐Pregnant at tii 9 ☐ Unknown	Fetal death		Ectopic pregnancy Other (specify) _	у				onth	Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death but	not resulting i	in the un	derlying cause giv	ren in Part I.	1				the cause of death?
ord	require een si hould t	ted I	Dichetes Mal	litur					Ue	1 □ Ye	-		bably AG Unknown
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V Ita	slcian: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth	26. Place of De			-		
o	g Phys er this eral dii): To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injury	28b.	Time of	3∏ DOA Stri	4 LI Nursing			nce 6 Ott		ify)
ion	ending ath. or: Afte he fun	atio	1 Natural 5 Pending investigatio		rear)	Injury		Yes 2 ☐ No					
Division or	al or Att s after de al Direct	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		r - At home, fa (Specify)	arm, stre	et, factory, office		28f. L	ocation (Str City or Town	eet and Numi , State)	oer or Rui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical (29a. Certifier 1	nysician: To the best of miner: On the basis of e and manner state	xamination at	e, death nd/or inv	occurred at the ti estigation, in my	me, date and plac opinion, death oc	ce, and o	lue to the ca the time, da	use(s) and mate and place,	anner as and due	stated. to the cause(s)
	To th	Me	29b. Signature and title of certifier				29c. Licens			29	d. Date signe		, Day, Year)
	2			~	Al- //A	(Tr		054656		700	12/10/	07	
	L		30. Name and address of person who	completed cause of dea	in (Item 23a)	(Type, F	(2 i l						
	Sta Registr		31. Date filed (Month, Day, Year)	BC1+ 3 Registrar	s Signature	Goa	de						

			1- For State of Maryland / Dep	partment of Health and I ertificate of Death	Mental Hygien	Z 11 11 1 .) `	9584
£ .	Physici		1. Decedent's Name (First, Middle, Last) Jenelle Mendez Prins		2. Date of Death Month D	ay Year	ne of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 4	c. County of Death	:45 ™
ilan y	Funeral Director		18628 Carriage Walk Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda, 1	Gaithersburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea August 5, 1	Montgomery 9. Birthplace (Sta Country) Texas	ate or Foreign
	D T		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			de City Limits
	the Man 28a-f sh notified	Director	Maryland Montgomery Gaithers 10e. Street and Number	sburg	100.0	1 ☐	Yes 2∏No
	eath with 1s 23a or must be	Funeral Di	18628 Carriage Walk Circle 11. Marital Status 12. Was Decedent Ever in U.S. 13	20879	Un	ited States	n
350	/2 hours after death with the Maryland fratural", or items 23a or 28a-f show ical Examiner must be notified at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerton Market Yes 2 No Specify: Market Market Yes 2 No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: Market Yes No Specify: No Specify: Market Yes No Specify: Market	exican	Black, White, etc. Specify: White	.,
9500-6171	permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan Inopartment of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. any injury or other traumatic event, the Me Irical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Giv	cedent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired) uter Programmer an tems Analyst	king In	 Kind of Business/Industry ternational siness Machin	.0.5
and 2	be filed with the period of th	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide		ies
aryia	and Mer s marke sumatic	2	Santiago Tomas Mendez 19a. Informant's Name/Relationship (Type. Print) 19b. Mai	Jenelle illing Address (Street and Number or Ru		or Town, State, Zip Code)	
re, Ma	f Health Item 27 I		20a. Method of Disposition 20b. Place of Dis	West Branch Circ1 position (Name of rematory or other place) Dece		ast, Maryland Location - City or Town, Stat	
baitimore,	artment care	/s	4 Donation 5 Other (Specify) Montgomer	y Crematorium 10,	2007 Bet	thesda, Maryla	and
0	Depar Impoi any ir		Milliam a. Himphilly 1101113	22. Name and Address of Facility Robert A. Pumphrey Fur 300 W. Montgomery Aver	nue, Rockvill	e, Maryland 208	
F	hysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Coronary Arteresulting in death)		or respiratory arrest,	Approx Interval Onset a 1 ye	rimate I Between and Death
	Examiner	<u>.</u>	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c				
00/00	physician and streets the burial-transit	dical					
O. DOX	to the tracking and Attending Priystrant: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med		B⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year
Jords, P.	n signed by		Part II. Other significant conditions contributing to death but not resulting in the Carotid Stenosis	underlying cause given in Part I.		o use contribute to the cause	
משבו ו	cate has tee	Completed by			24a. Was an autopsy performed?		of cause of
N I	is certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	th (Check only one) ome 5 X Residence	6 □Other (Specify)	
	To use nayple of variating rigstrant. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how inj	ury occurred	
	within 24 hours after death. To the Puneral Director: After completely filled in by the funeral completely filled in the funeral complete	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route i te)	Number,
	in 24 hou he Funer	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause(irred at the time, date a	s) and manner as stated. nd place, and due to the cau	use(s)
	To the	Ň	29b. Signature and title of certifier	29c. License number D35965		ecember 10, 20	
	12		30. Name and address of person who completed cause of death ((Item 23a) (Type		Olnow M	cvland 20832	
	Sta Registr		David B. Harding, M.D. 18111 Prince 31. Date filed (Month, Day, Year) OFC 1 1 2007	e ruitip Dr. #300,	orney, Mai	yrand 20032	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Registrar UEU I I 2007 Abdus 15 April 1996			е	31. Date filed (Month Day, Year)	007 32 Jegistra	ar's Signature	1-0		-,-	1			+4 /

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anend items 10b d per fin 874 12-11-07 yt.

State or Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 186 SEMYON 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA If Under 1 Year Months | Days If Under 24 Hrs Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Tunera Months I 1 **X** M 2 □ F RUSSTA 60 Director 148-60-9373 02/13/1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Fyzamina. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 ▼ ★ MD BALTIMORE BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 RUSSERN COURT APT. 21215 T-2 <u>U.S.A.</u> Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MEAT CUTTER SAFEWAY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NAUM REIDER HANA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BELLA REIDER / WIFE 2 RUSSERN COURT APT. T-2 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OHEB SHALOM MEMORIAL 12/09/2007 REISTERSTOWN, MD 22. Name an A ress of Facility 21. Signature of Funeral Secrice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDEN DEATH /Medical Due to (or as a consequence of): Examiner (EROWAN ARTEM DISEASE. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer ce of): Examiner bypertension To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2/ No 1∐ Yes funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Certification: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/7/07 KErr NID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KERR Colom 6it, MO 755 CEDAR CAUE 32. egistrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc /8874 12-11-07 vt and Mental Hygiene 39587 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 2, 2007 **Physician** 8:15 P M Maurice Spencer Jr. Maxwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2516 Franklinville Road Joppa Harford 8. Date of Birth (Month, Day, Year)
July 14, 1953

9. Birthplace (State or Foreign Country)
West Virginia If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Hours Min Director 223-82-7934 54 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23s or 28s-f show any highry or other traumatic event, the Mudical Examinar must be notified at once. 1 ☐ Yes 2 No Completed by Funeral Director Maryland Harford Be l Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Creswell Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 € Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 4 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Alice Faulk Maurice Maxwell Spencer, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2516 Franklinville Rd., Joppa, MD 21085 <u>Deborah J. Magness / Friend</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 GCremation on 5 □ Other (S 3 Removal from 4 Dogation of (Spegify) Hilltop Service Corp. 12-7-07 Towson, Maryland 21. Sign yury of Funeral McComas Funerally Home, P.A. Þ 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complication shock, or heart failure. List only one cau used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications the Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of). physicien and or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 robably 4 □Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform rmed2 2 ☐ No certificete 1 Yes Be 25. Was case referr of o medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home dence 6 NOther (Special) 1 Yes 2 No Certification: To After th 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred fiancee 5 Pending investigation
6 Could not be determined death. 1 Yes 2 No 2 Accident Director: / 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, stc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 I Homicide 29a. Certifier tying Physician: To best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and t

31. Date filed (Month

the

ar's Signature

2007

29c. License number

10030149

29d. Date signed (Month, Day) Year) 0

04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep.	rtificate of Death		leg. No.2007 39588
	Physicia		1. Decedent's Name (First, Middle, Last) THOMAS JEFFERSON SHOFF JR.		2. Date of Deat Month Decembe	Day Vees
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 831 Angel Valley Court	4b. City, Town, or Location of De		4c. County of Death Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Hrs. 8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign
*	Director		169-26-0270	Working Days Hours W	July 3,	
	aryland show d at	ř	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits 1
	r 28a-f notifie	Director	Maryland Harford Edgewood 10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?
	sath with s 23a o nust be	eral D	831 Angel Valley Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21040		USA 14. Race - American Indian,
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	1 □ Never Married 2√2 Married 1√2 Yes 2 □ No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2√√2 No Specify:	r (Specify fes of No- uerto Rican, etc.)	Black, White, etc. Specify: White
2-0	n 72 ho "natur edical I	leted	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of t DO NOT use retired)	working	16b. Kind of Business/Industry
2121	be filed within 72 ho tal Hygiene. of other than "natul event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ronics Technici	an	Dept. of Defense
Maryland		Be	17. Father's Name (<i>First, Middle, Last</i>) Thomas Jefferson Shoff Sr.		Name <i>(First, Middle, I</i> Mae Bowers	·
ary	2 should and Men Is marke	으		ng Address (Street and Number or		
	1 and Health em 27 ther tr		20a, Method of Disposition 20b, Place of Dispo	osition (Name of		own, Maryland 21787 20c. Location - City or Town, State
Baltimore,			4 Donation 5 Other (Specify) Hilltop	Service Corp 12		Towson, Maryland
Ball	permit. Page Department of Important: If any Injury of		21. Sign fur of Funeral Single Literasee	2. Name and Address of Facility ICCOMAS FUNETAL I .317 Cokesbury Ro	Home, P.A. Dad, Abing	gdon, Maryland 21009
			23a. Part1. Enter the disease, or complications that of used the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as card	diac or respiratory arr	rest, Approximate Interval Between
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Vascular,	Accide. laryn	17
	Examiner	- a	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	of the	laryn	X
K	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Pue to (or as a consequence of):			
68/60,	rificate be executed ig physician and as the burial-transit		Due to (or as a consequence of):			
× 68	⇒ o α	Medical	IF FEMALE:			
O. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/N		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P	requires that een signed b hould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		bacco use contribute to the cause of death? 'es 2 □ No 3 □ Probably 4 🔣 nknown
II Records,	The larate has	Completed			24a. Was a autops perfor	sy prior to completion of cause of
VITAI	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	Death (Check only on	ne) lence 6 □Other (Specify)
on or	ding 1. After fune		27. Manner of Death 1 ☑ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28a. Date of Injury (Month, Day Year)			ow injury occurred
DIVISION	al or Attending s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	Street and Number or Rural Route Number, m, State)
	To the Hospital or Avivitin 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	wastigation in my aninian death o	annurred at the time of	data and place and due to the source(a)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	33	Bel Air, MD 2005
	4×1		30. Name and address of person who completed cause of death (Item 23a) (Type Robert S. Kuralit MD 104 P)	Print)	Ste 102	Bel Air MA ZINE
-	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 1 2007 Registrar's Signature	who will		1-1, 111, 110 100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** MILTON AM VINCENT SMITH December 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner tarfor AIR Health & Rehab Center Air If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□F Months Hours Director 220-22-0989 92 June 13, 1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Archer Street 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Cook Restaurtant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Vincent Smith Charlotte (nmn) Wilson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel W. Smith / Wife 108 Archer Street, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 Crent 3 Remov Berkley Cemetery 12-14-07 Darlington, Maryland 4 □ Donation 5 □ 21. Sign e of Funer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) anced /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown by s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy this certificate har al director, page perform or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place eath Check onl one 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. May er of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🗌 Yes 2 No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 2007

DHMH 17 Rev 1/2001

Registrar

anend them 19a year ith a separtiment of Health and Mental Hygiene 1- State Registrar Amend #19b Per Inf G874 12/20 Anticatte of Death Reg. No U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year MARI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Renaissance Gardens Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 1 1919 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 12:50 **Funeral** Yrs 213-38-3538 88 **Director** <u>Pennsylvania</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 XNo Director MD Parkville Baltimore r 28a-f 12/01/01 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 8800 Walther Boulevard, Apt. 4506 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Snyder, Mark Elementary/Secondary (0-12) College (1-4or 5+) marked other than Budget Officer Department of Defense Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fillealth and Mental H m 27 is marked ott George Godfrey Snyder Carrie Wagner 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau Hargot Hiltz - Daughter 5106 Huntingtown Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/7/2007 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide □ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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□ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place at the cause at the 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type BMLE Burent 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 1 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1_ For State	State of Maryland	· ·		Hygiene	00501
		_	Registrar		Certificate of I		Reg. No. UU/	39391
12	Physic	ian	1. Decedent's Name (First, Middle,	Last)		2. Date of Month	n Dav Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution,	give street and number)	4b City Town or	r Location of Death	4c. County of De	DOZO M
4	LAdilli	ICI	Good San	waston Hos	m 6 Bolt	comme h	17)	
	Funeral		5. Social Security Number 6	S. Sex 7. Age (In yrs. ias	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Monte	of Birth 9. Bi	rthplace (State or Foreign country)
	Director		253-30-5949	10 M 200F 83	Yrs. Worth's Days	5.	9 1924	3A
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, "	Town or Location			10d. Inside City Limits
	Mary Fige	to	M	Ba	ltimore.			1 Yes 2 No
	with the Maryland a or 28a-f ehow	lirec	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	death wi	Funeral Director	3409 Mary	Avenue	୍ଲା ବାର ।	4	U.S.	A
	er de	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc	or No- 14. Race - Am Black, Wh	
336	hours after tural', or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:	Specify:	
5-0036	7.72 hours after death with the Marylar "netural", or Items 23a or 28a-1 ehow dical Examiliar : ust by multied at	ted	15. Decedent's	Education	16a. Decedent's Usual Occupa (Give kind of work done of	ation	16b. Kind of Busines	s/Industry
21	within iene.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	during most of working		
12	Hygier Hygier other th		17. Father's Name (First, Middle, La	and)	Janatoria		Domest	-1C
Maryland	should be filed withir of Mental Hygiene. marked other then matic event, the Mental Men	Be C	1 6	nans		18. Mother's Name (First, Mi	-	
ary	2 shoul and Me is mark	70	19a. Informant's Name/Relationship		19b. Mailing Address (Street a	and Number or Rural Route N		Zip Code)
Ž			Barbara Keith	IX.	EIGG O I		E Baltimore,1	
ore	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition 1 Durial 2 □ Cremation 3	20b. Plac	e of Disposition (Name of etery, crematory or other place	Date	20c. Location - City o	r Town, State
Baltimore	permit. Pages Department of Importent: If I any Injury or one		4 Donation 5 Other (Spe		ity Cemetery	12.07.acc	of Baltimor	e MD
3ali	permit. Pag Department Importent: any Injury once.		21. Signature of Funeral Service Lic	ensee d	22. Name and Address	ss of Facility Vaugn	07 Baltimor C. Greene Fun	eral Services
	00500		220 Part Fatar the disease are	/. <i>J</i>	4905 York	Ind Baltimo	re, MI) ala	K .
1			shock, or heart failure. List on Immediate Cause (Final		po not enter the mode of dying	g, such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Nivertica	was pla	erdus		
	Examiner		1	Due to (or as a consequent	directi	ca (0 825		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	nce of):		A /	
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687	ficate phys s the	edicai		d. Drew		0,00		
Вох	leath certifica attending ph ifor use as th	Z/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	y		23d. Date of de	elivery
	The law requires that the death certific te hes been signed by the attending p bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown			Month	Day Year
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ls,	ires tha signed i be det		Part II. Other significant conditions	s contributing to death but not resulting	ng in the underlying cause give		Did tobacco use contribute l	o the cause of death?
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of Vital Records,	The lav	Completed by	- Chicach	1/ //	imila		Was an autopsy prior to death?	completion of cause of
tal			25. Was case referred to medical	5 hellit	n S	1 ☐ Y	es 2 1 Ye	s 2 No
Ę.	S 50	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐Inpatient 2 ☐ ER	/Outpatient 3 DOA Othe		Residence 6 Other (Spe	ecify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 ☐ Pending		b. Time of 28c. Injury Nork		ribe how injury occurred	
sio	Attendil deeth. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ho	M 1 1 1	res 2□No		
Division	ofter deeth efter deeth Director: I in by the	Certification:	4 Homicide determine		s, farm, street, factory, office	28f. Locati City o	on (Street and Number or F r Town, State)	iural Route Number,
_	s Hospital 124 hours e e Funerel letely filled		29a. Certifier 1 Certifying	Physician: To the best of my knowle	doe. South consensed at the five	e data and place, and due to	the causals) and viamor s	e stat et
	To the Hospital or Attending within 24 hours efter deeth. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 ☐ Medical Ex one)	aminer: On the basis of examination and manner stated.	and/or investigation, in my op	pinion, death occurred at the ti	me, date and place, and du	e to the cause(s)
	To the l	Ň	29b. Signature and title of certifier	11	29c. License		29d. Date signed (Mon	th, Day, Year)
,			Khand	hot knee	Day Du	0063917	12/4/0	7
	7		30. Name and address of person wh	o completed cause of death (Item 23	Sa) (Type, Print)	21 0	B > 14 110	21239
100	Sta	te	31. Date filed (Month, Day, Year)	32. Alegistrar's Signature		- over pluce	· 0) It Ih	n we MD
	Registr		DEC 1 1	2007 Marie S	Aparle .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

MD 21061

Approximate Interval Between Onset and Death

2 mos

DE

Black, White, etc.

White

2. Date of Death

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 27. Manner of Death
1 Natural
2 Accident Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of gertifie 10 ise of death (Item 23a) (Type, Print) gistrar's Signature 31. Date filed (Month State Registrar DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Month

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ő6 2007 **Physician** 1:00 P M LOUISE SEWELL December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 434 Burwood Avenue Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) Vest Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F 12/08/1919 West 87 214-28-3000 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County la or 28a-f show t be notified at show 1 ☐ Yes 2X No Directo Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 434 Burwood Avenue USA items 23a (iner must b death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner and. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Franklin McNemar Bessie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard W. Sewell, Sr. Spouse 434 Burwood Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Cemetery 12/10/2007 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave., S.W. Glen Burnie MD mov918 Singleton Funeral & Cremation Services Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 200 1 TYes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 1 Yes 2 No Hospital: 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Delatural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, DEC 1

30. Name and address of person who completed

D

Year) 1 200

DHMH 17 Rev 1/2001

çause of death (Item 23a) (Type

Registrar's Signature

29c. License numbe

29d, Date signed (Month, Day, Year)

	1	For State Registrar	State of	Marylan		rtment of				giene Reg. No.2 (007	39594
Physicia		1. Decedent's Name (First, Middle,	Last)					I	2. Date of Dea		00 ^Y 7°ar	3. Time of Death 5:15 P. M
/Medica	al 🤄	Wilma E. Stamm 4a. Facility Name (If not institution, g	give street and num	nber)		4b. City, Town	n, or Location				ity of Death	· · ·
Examilie		Aspenwood Assist	ed Living	3		Silver	-				gomery	
Funeral Director		5. Social Security Number 6 413-50-5529	. Sex 1☐ M 2☑ F	7. Age (In yrs 96	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birt (Month, Da Aug • 2]	, Year) 911	Mis	place (State or Foreign ntry) Souri
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	ral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo 10e. Street and Number 14400 Homecrest 11. Marital Status	Road #53	Sil	y, Town or Lo ver Sp S. 13.		06 of Hispanic C	Origin? (Spe	ecify Yes or No		State	can Indian, etc.
Maryland Z1Z15-UU36 d 2 should be filed within 72 hours afti tith and Mental Hygiene. Z7 is marked other than "natural", or traumatic event, the Medical Examir traumatic event,	۾	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's (Specify only highest	If Yes, Given Year or Date Education	z <u>w</u> No re ates:	16a. Deced	1 ☐ Yes 2 ☑ I dent's Usual Oc kind of work do	cupation		ing	Spec 16b. Kind of	ony.	√hite ndustry
within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	no NOT use re memake:	tired)		5	O	wn Hor	ne
and Z A be filed antal Hygi ed other s event, t	Be	17. Father's Name (First, Middle, La Bernard Henry Ho							e (First, Middle, gelina		ame)	
arylanc	ဍ	19a. Informant's Name/Relationship				ng Address (Str	eet and Num	nber or Rura	al Route Numb	er, City or Tow		
		Lynne S. Kovach	/ Daught			Park St			y Chase	20c. Locatio		
IMORE, Marylal Pages 1 and 2 should b ment of Health and Ment ant; If item 27 is marked lury or other traumatic e		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3		State 205. f	cemetery, crei	sition (Name o matory or other	place)					
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe		4 □ Donation 5 □ Other (Social Section 21. Signature of Funeral Section 1.1)			Rc	bert Ad A	dress of Fay	Funer	al Home/	Bethsda-	Chevy (aryland Thase, Inc.
T 00 - 20 0		23a. Part1. Enter the disease, or c shock, or heart failure. List o	Omplications that c	MO08							D 208	14-3501 Approximate Interval Between
Physician		Immediate Cause al disease or condition resulting in death)	_a. Coron	ary Art		Lsease						Onset and Death
/Medical Examiner				or as a conseq	guence of):							
) per tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a conseq	guence of):							
8760, https://example.com/resoluted-nysician and the burial-transit	ical Exar	that initiated events resulting in death) Last	Due to ((or as a consec	juence of):							
BOX 6	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ointh 2 ☐ Feta nant at time of o	aldeath 3	⊒Ectopic pregn ⊒Other (specif					Date of deli	very Day Year
ds, P.O. Laires that the de signed by the a d be detached if	þ	Part II. Other significant condition Severe pulmonar			sulting in the u	ınderlying caus	e given in Pa	rt I.		tobacco use c Yes 2∑No		the cause of death? bbably 4 ☐ Unknown
Vital Records, stdan: The law requires to certificate has been signe rector, page 2 should be contracted.	Completed										prior to o death?	topsy findings available completion of cause of 2 ☐ No
Or Vital I Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2] ER/Outpatie	nt 3 DOA	Othor:		h <i>Check onl</i> ome 5□ Res		As Other (Spec	ssisted Sify) Living
On Or ding Phy h. After this funeral c	-	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigs	28a. Date (Mon	<u> </u>	28b. Time of Injury	of 28c.	Injury at Work? 1 ☐ Yes 2		28d. Describe	how injury oc	curred	
Division o To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	200. Flace	e of injury - At h ing, etc. <i>(Sp</i> ec	ome, farm, st	reet, factory, of	fice		28f. Location City or To	(Street and Nu own, State)	umber or Ru	ral Route Number,
the Hospital or hin 24 hours afte the Funeral Dir	ledical C	29a. Certifier 1 🔀 Certifying (Check only one)	Physician: To the Examiner: On the b and man	e best of my kn basis of examin liner stated.	owledge, dea ation and/or i	th occurred at t nvestigation, in	he time, date my opinion,	and place, death occur	and due to the	e cause(s) and e, date and pla	d manner as	stated. to the cause(s)
To the within То the сощрк	Med	29b. Signature and title of certifier	Juest	_		29c. Li	cense numb	er				h, Day, Year)
		10					D550	73		Decem	ber 10), 2007
12		30. Name and address of person Helene Dumont	M.D.,	8700 G	eorgia	Avenue	#400	, Silv	ver Spr	ing, Ma	arylar	nd 20910
Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Sign	ature	care						

State Registrar

Marian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** eral Gen if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**M**M 2□ F 148-14-7655 Director February 14, 1926 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Ellicott city Director Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Maplewood Drive USA 10072 21044 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 KNo 3altimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pollack William Jane Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE 10072 MAPLEWOOD PRINE, ELLICOTTCITY, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry December 10,2007 Hanever, MO 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee Hanover MO 21076 7522 Connelley Drive suite P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Alzheimers 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Liffle

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1

32. gistrar's Signature

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** THOMAS HOWARD R. 5:15 PM December 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**□M 2□F Days Hours Director 220-42-6976 MARYLAND 11/27/1946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other then "netural", or items 23a or vent, the Medical Examinar must be 6715 GLENKIRK ROAD 21239

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
14. Armed Forces?
1 □Yes 2 □ No
1f Yes, Give
Year or Dates: VIETNAM 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS CHAUFFEUR TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD R. THOMAS, SR. EDNA E. RAAB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a EDNA E. THOMAS/MOTHER 6715 GLENKIRK ROAD BALTIMORE, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 12/13/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23. Inflix Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician una (ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offburial-transit Due to (or as a consequence of): Physician/Medical the use as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cancer 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 \(\text{No} \) 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? al or Attending P s after death. i Director: After After Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerei Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 7, 2007 O SUBBLEENE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 STREET BALTIMORE, MD 21201 32. Rehistrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 39598 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Pauline Elizabeth Tauber 12-3-2007 2:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Retirement Center Catonsville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 8, **Funeral** 1 □ M 2 X F 87 212-05-2042 Maryland 1920 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County ges 1 and 2 should be filed within 72 hours after deeth with the Marylar it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or iteme 23a or 28e-f show or other treumatic event, the Medical Examinant must be notified. 1 Yes 2 No MD Baltimore Director Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Maiden Choice Lane 304SRG 21228 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉No Specify: Specifywhite Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: If tem 27 is marked otherny injury or other treumatic event 17. Father's Name (First, Middle, Last) Be John William Grove Lora Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia A. Donnelly/Daughter 2103 Tufton Ridge Rd. Reisterstown MD 21136 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Lakeview Memorial Park Burial 2 ☐ Cremation 3 ☐ Removal from State 12-7-2007 Sykesville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Annorose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 lend 231 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NEONE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 1 Yes 2 → Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 28a. Date of tnjury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No М 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funerel f Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertitier 2 (Enk 30, Name and a kiress of kirson who completed cause of death (Item 23a) (Type, Print) 9751 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gosele Registrar

			1 - State of Maryland / Der FH G8/4 12 18/0	partment of Health and M ertificate of Death	lental Hygid Reg	ene a. No. 2007 39599
		Ш	Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death
H	Physici /Medic		William M. Vanik, Jr.		ECEMBE	Day R 05, 2007 03:05M
	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death	on	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 218-38-3916 6. Sex 7. Age (In yrs. last birthd	Months Davs Hours Min.	8. Date of Birth (Month, Day, 10 08-26-19	9. Birthplace (State or Foreign Country) 41 Maryland
	puq ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	fanyle shor	or				1 □Yes 25 No
	the N 28a-	Director	Maryland Harford Fore	st Hill 10f. Zip Code	10	g. Citizen of What Country?
	3a or		1719 B. Landmark Drive	21050	II	.S.A.
	ems 2	Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exteniner must be notified at once.	by Fu	1 ☐ Never Married 2 🔯 Married 1 ☐ Yes 2 🔁 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	1110411, 0101,	Specify: White
21215-0036	2 hou	ted	15 Decedent's Education 16a De	ecedent's Usual Occupation	10	6b. Kind of Business/Industry
215	ithin 7 le. lan "r Med	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of worki e. DO NOT use retired)	ng	
	led wi lygier her th nt, the			il Manager		Food Industry
Maryland	12 should be filed wand Mental Hygie is marked other tranmatic event, th	Be (17. Father's Name (First, Middle, Last) William M. Vanik Sr.	18. Mother's Name	, ,	aiden Surname)
Ž	shoulk nd Me mark matle	P		ailing Address (Street and Number or Rura		City or Town, State, Zip Code)
	of Health a Item 27 is other tra		Suzanne Vanik (Wife) 171	9 B Landmark Drive	Forest H	ill. MD 21050
ore,	of He fitem		20a. Method of Disposition 20b. Place of Di			Oc. Location - City or Town, State
altimore,	ment ment ant: I		4 Donation 5 Other (Specify) St. Mar	y's ChurchCem. 12-1	0-2007 P	ylesville, Maryland
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sch Inc. 610 W. MacPhai	imunek Fu 1 Rd Bel	neral Home of Bel Air Air, MD 21014
г			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	or respiratory arres	st, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. ANDXIC ENCEP	HALOPATHY		Onset and Death
	/Medical Examiner		Due to (or as a consequence of): CARDIAC ARRE	CT		1
		er	Sequentially list conditions, if any, feading to immediate cause. Either Underlying	· too?		
	cuted id ransit	Examiner	Cause (Disease or injury that initiated events ISCHEMIC HEA	RT DISEASE		
Ő,	e exe	EX	resulting in death) Last Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit	dical	d			
_			IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
P.O. Box	death e atter d for u	by Physician/M	1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Vas. 2 ☐ No. 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
0	at the by the tache	hys	9 ☐ Unknown			
Records, F	The law requires that the death certif tte has been signed by the attending age 2 should be detached for use at		Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
S	w req	Completed			24a. Was an	24b. Were autopsy findings available
	The lav	ошо			autopsy perform 1□ Yes 2	prior to completion of cause of ed? death? ☑No 1 ☐ Yes 2 ☐ No
Vital	ysiclan: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?	26. Place of Death		1
7	physic this co	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			nce 6 Other (Specify)
u	iding Phys h. After this funeral dir	jon	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 1 ☐ Corplete (Investigation)		28d. Describe hov	v injury occurred
Division or	Atten death	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,		28f. Location (Stre	eet and Number or Rural Route Number,
	s after al Dire	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, r	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dependence on the basis of examination and/of and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the car red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
)	1		1 Same	D3Ø263		17-05-07
	8		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		
	Sta	to	04 0 4 50 1 44 4 50 14 50 14 14 14 15 14 14 14 15 14 14 14 15 14 14 14 14 14 14 14 14 14 14 14 14 14	R DRIVE TOWSON,	MARYLA	ND 21204
	Registr	_	DEC 1 1 2007	303482		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2<u>007</u> 5, 7:45 PM Marie Elizabeth Wirth Dec. 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Glen Meadows Glen Arm Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🖫 F 87 May 24, 1920 Maryland 217-03-1843 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 1 ☐ Yes ACKNO Glen Arm Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21057 11630 Glen Arm Rd., #117 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes OF No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Payroll Clerk Cross & Blackwell 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie McElroy Walter Mundt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son 9617 Northwind Rd., Baltimore, MD 21234 Joseph J. WIrth, Jr. -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Gardens of Faith Cem. 12/08/07 | Baltimore, MD 21. Signature of Funeral Service Lid 22. Name and Address of Facility 8800 Harford Road, Blatimore, MD 21234 Evans Funeral Chapel & Cremation Services - Parkville 23a. Part I. Enter the disease, or complessor heart failure. List only of Approximate Interval Between Onset and Death fatio is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. Immediate Cause (Final disease or condition resulting in death) Septicemia 8 hours Due to (or as a consequence of): 6 days Pneumonia, N.O.S. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisses of injury that initiated events resulting in death) Last Due to (or as a consequence of) Clostridium Difficile Colitis 3 months Due to (or as a consequence of) 4 months ıs Cholecystiti<u>s</u> 23d. Date of delivery 3 Ectopic pregnancy eath Year Month 5 ☐ Other (specify) 23e Did tohacco use contribute to the cause of death? ng in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? Congestive Cardiac Failure 24a. Was an autopsy perform 2□ No 2 X No 1 Yes 1□ Yes

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Hospital or Attending Physician:

Fo the

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event

injury or other traumatic event,

within 72 hours after

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examiner

and attending physician and K Physician/Medical ed by the a detached f Completed by page 2 Certification: To Be s after death.

I Director: After this of in by the funeral d within 24 hours aft

To the Funeral Di

completely filled in

	d. Gangrenot
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unkno yn	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown
	ns contributing to death but not resulting

Chronic Renal Failure 25. Was case referred to medical

Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27 Manner of Death 5 Pending investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide determined

26. Place of Death (Check only one) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

GROSPRIAN #179 BACTIMOREMS 21278

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) December 6, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

RTM ANA NOTHER WY 2 E KOMMG

2007

31. Date filed (Month, Day, Year) State DEC 1 1 Registrar

1 Naturai

29a. Certifier

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 07

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:45 P^M 2007 Michael Henry Ward December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 501 Little John Hill Sherwood Forest Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) APR 8 1944 Days 1 X M 2 □ F England 266-83-5817 63 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 501 Little John Hill 21405 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7 Health and Mental Hygiene. Graphic Design College (1-4or 5+) Elementary/Secondary (0-12) traumatic event, the Photographer Photography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Willam Ward Dorothy Paige ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is any Injury or other tra Jill Berie Ward - wife 501 Little John Hill, Annapolis, MD 20a. Method of Disposition
1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 12/10/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ances Mouth **Physician** /Medical Due to (or as a conseq once of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit the death certificate be executed Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 2 ☐ Accident 5 Pending investigation Injury To the Hospirar ... within 24 hours after death.
To the Funeral Director: After a first on the Funeral Director After a first of the furth of the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature_and title of certifier MID D39505 December 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lov. Glen Sumie, MD. 210 & 2 10 ogistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39602 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:45AM M Wilbur L. Welch December 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Health Care Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F 85 Director 2,1922 DE 190-16-9050 Aug. Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director MD Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2932 Bloom Road 21048 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify. 3√ Widowed 4 Divorced Year or Dates White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12 Sergeant Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Welch Brooksie Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1413 Broadway Road, Lutherville, MD Wilbur L. Welch, Jr. Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 12/10/07 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Com Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Imm diate Cause (Final se or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed sician and burial-trans Due to (or as a consequence of): physician a Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a P.O. 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 autopsy page perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ဥ 1 🔲 Inpatient this After thi 28a. Date of Injury 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: Division (Month, Day or Attending 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

 \mathcal{F}_{x} State 29b. Signature and title of certifier

31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

4

Registrar DHMH 17 Rev 1/2001 id de

			State of Maryland /		rtment of He			2 111	7 39603				
şŝ.	Physici	an	1. Decedent's Name (First, Middle, Last) THOMAS WHIPO		2. Date of Death 2. Date of Death 2. Date of Death 2. Date of Death 3. Time of Death 3. Time of Death								
	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	CCOII.	4c. County of Death					
	Examin	er	Northwest Hospital Center		Randa1	1stown		Baltimore					
	Funeral Director		5. Social Security Number 215–58–0506 C. Sex XM 2 F 7. Age (In yrs. last to the security Number 56	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 23,	^{Year)} 1951	Birthplace (State or Foreign Country)				
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	eation				10d. Inside City Limits				
	Maryla f show	ō		sters					1 □ Yes 2\\X No				
	the f	rect	10e. Street and Number		10f. Zip Code		19	g Citizen of W	that Country?				
36	th with	alD	614 Glynock Place		21136			of America					
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ★ Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1★★ Ses 2 □ No If Yes, Give Year or Dates: unk.	lf If	Vas Decedent of His Yes, specify Cubar ☐ Yes XX No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. : White				
9	2 hour atural cal Ex	ted k	15. Decedent's Education 16	6a. Decede	ent's Usual Occupa	tion	ing 1	6b. Kind of Bu	siness/Industry				
215	thin 7, ie. ian "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	`life. D	OO NOT use retired)	Ü	ing						
121	e filed wi al Hygier other th vent, the	Co	2 17. Father's Name (First, Middle, Last)	Tı	ruck Driv	rer 18. Mother's Nam	e (First Middle M		umber Company				
Maryland 21215-0036	should be find marked of marked of	To Be	ROBERT B. WHIDEO. SR			DOROTH	11	}	-,				
ary	2 should and Men Is marke aumatic		, , , , , , , , , , , , , , , , , , , ,	9b. Mailing	g Address (Street a	/) //i		. 44	State, Zip Code)				
	and 2 lealth m 27 I		DOROTHY WHIPPE MOTHER 1		RABBURY .		ING8 Mh		Situation State				
Baltimore,	Pages 1 and 2 should nent of Health and Mer nt: If Item 27 Is marke iry or other traumatic		XXBurial 2 Cremation 3 Removal from State Garri	etery, crem S on I	sition (Name of natory or other place Forest	Dec.	14,		City or Town, State				
亞			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	rans	Cemeterv	: : 2007		Owings	Mills				
Ba	permit. Departn Imports any Inju		Man (Company).		Name and Addres Ckhardt F 1605 Reis	uneral C terstown	hapel, P Road, O	.A. wings N	Mills, MD 21117				
8760,	Physician / Medical Examiner bub/sician and bub/sician upon situe private the private transit	dical Examiner											
.O. Box 6	the death certif y the attending ched for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death	ath 3 🗌]Ectopic pregnancy] Other <i>(specify)</i>				te of delivery nnth Day Year				
ds, P.	es De de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death										
Vital Records,	e law has b	Be Completed											
ital			25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one						
or V	ys dir	To	1 ☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/	nce 6 🗆 Oth									
uc	ding 1. After fune	ion:	1 ☐ Natural 5 ☐ Pending (Month, Day Year)	Bb. Time of Injury	Worf	/ at <br Yes 2 □ No	w injury occur	injury occurred					
Division	or Attending iffer death. D rector: Afte in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre			28f. Location (St. City or Town	treet and Number or Rural Route Number, n, State)					
	Hospital 4 hours a Funeral I tely filled	edical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination										
D	To the within 2 To the complete	Med	29b. Signature and title of certifier	MD	29c. License	e number	8	9d. Date signe	in (Month, Day Year), 2007				
6			30. Name and address of person who completed cause of death (Item 23		Print)	north	TWST	MOBI	ntal Carly				
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	1	reserv								

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day, Year) DEC1 1

ORIGINAL

32 Registrar's Signature

			For State		State of M	arylan		artmen rtificat				lental Hy	gier Reg. i	00	0.7	3	960	
	t.	-	1. Decedent's Name (First,	Aiddle, La:	st)			·····		Joan	<u> </u>	2. Date of D	eath	-	V / /	3. T	ime of Death	
	Physici /Medic		Naom	^	Zelk	40						Deceu		C	Z00 7	' 5	, M	
	Examin		4a. Facility Name (If not inst								of Death				y of Death			
			Ruxton Heal 5. Social Security Number	th &			ast birthday)	Pi If Unde	kesv	ille IfUnde	r 24 Hrs.	8. Date of Bi	rth		timor		State or Foreign	
Ь.	Funeral Director		216-01-5746		□M 2√2 F		39 Yrs.	Months	Days	Hours	Min.	(Month, D 2/6/19	a <i>y, Ye</i> :	ar)	Balt	intry)	State or Foreig Marylan	
4.5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decede			100 City	, Town or Lo	anting		1							side City Limits	
		or	Maryland Ba	ltim	ore		ikesv.										⊒Yes 2. No	
		Director	10e. Street and Number	T CILIT	<u> </u>		TITCD V	10f. Zir	p Code				10g.	Citizen of	What Co	untry?		
		al Di	7 Sudbrook	Lane	9			21	208				Ü	nited f And	d Sta erica	tes		
	ems ser mu	ıner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?					6. 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican					0-		ce - Amer		ian,	
36	s afte	by Funeral	1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Dive		1 ☐ Yes 2⁄23 If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify 5				Speci	ity: W	hite	9	
21215-0036	2 hour atural cal Ex	ted t			ducation ade completed)	16a. Dece	16a. Decedent's Usual Occupation					16b	. Kind of E	Business/I	ndustry			
215	thin 7. e. an "n Medi	Be Completed	(Specify only in Elementary/Secondary (0-		College (1-4or	(Give kind of work done of life. DO NOT use retired			iunng mo	St of Work	ang		c.c.;	- 0	1.4			
121	filed wi Hygien ther the	Con		2				Sale	:S	10 Moth	nada Nam	e (First, Middle				Supplies		
Maryland	d be findal Hed ott	Be	17. Father's Name (First, Mi Simon Herm		,					10. IVIOU		Zinber		ien Surna	ine)			
T.	should be fi and Mental H s marked ot umatic ever	Tol	19a. Informant's Name/Rela	tionship (Type. Print)		19b. Mailii	ng Address	s (Street	and Numi		ral Route Num		ty or Towr	n, State, Z	ip Code)	
	and 2 salth a n 27 is		Lois B. Rich	ter/	daughter		600	Stra	ffan	dri	ve Ur	nit 303	Ti	moni	arn, M	D 2:	1093	
ore,	permit. Pages 1 a Department of He. Important: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	tion 3.	Removal from State	20b. P	lace of Dispo	sition (Namatory of	me of other plac	e)	Dece	Date mber	20c	. Location	- City or	rown, St	ate	
Ë.			4 □ Donation 5 □ Oth	er (<i>Specit</i>	(y)	Cha	emetery creating Fundament				10,	2007					Marylan	
Baltimore,			21. Signature of Furleral Se	15.3				2325	York	road	d Tim	onium,	Ma:	rylar	remat nd 21	ion .093	Ctr.,P	
(9-			23a. Part1. Enter the disea shock, or heart failure	se, or com List only	plications that cause one cause on each I	d the death ine.	n. Do not en	ter the mod	de of dyir	ig, such a	s cardiac	or respiratory	arrest,			Inter	oximate val Between et and Death	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	100	a. Em	ph	sen	2								01130	t and Death	
	/Medical Examiner		resulting in deathy		Due to (or as	a consequ	ience of):											
	2	er	Sequentially list conditions, if any, leading to immediate		b													
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	c									-				
30,	ficate be executed physician and is the burial-transit	I Ex	Due to (or as a consequence of):															
68760,	cate b	edical		•	d													
			IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, outcome									23d. D	ate of deli	verv		
. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)								Month					Year		
P.0	at the by the	hys	9 ☐ Unknown		9∐Unknown							T						
	ires that signed k	by	Part II. Other significant co	nditions	contributing to death t	out not resu	ulting in the u	nderlying (cause giv	en in Pari	il.		tobace] Yes	co use co 2∐ No			ise of death? 4 □Unknow	
Records,	w requir been si should I	Completed												1	/			
Rec	The law ate has l	ldu										aut	24a. Was an autopsy performed? 24b. Were autopsy findings as prior to completion of caudeath?					
tal			25. Was case referred to m	edical						26 Plac	ce of Deat	1 Yes th (Check only		No	1 🗆 Yes	2 1	10	
or Vital	Physician: this certificant	To Be	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 D	OA Oth			ome 5□Res		9 6 □0	ther (Spec	cify)		
0 1	0 + E		27. Manner of Death 1 Manatural 5 □ F	ending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o	of	28c. Injur Wor			28d. Describe						
sio	Attending r death. sctor: After by the funer	catic	2 Accident investigation M 1 Yes 2 No							□No								
Division	or At after d Direct in by	Certification:	2 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R City or Town, State)									nber or Hi	rai Hou	le Number,				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Me												cause(s)			
	the the the the the the the the the the	Medical	one) 29b. Signature and title of c								29d. Date signed (Month, Day, Year)							
	F ≥ F 8		1 / 601000h						N15872				29d. Date signed (Month, Day, Year) December 7, Zas; Trm Or 2 (20)					
	\cap		30. Name and address of p	erson who	completed cause of	death (Item	23a) (Type,	Print)))	_	V	CIN	100-	9	ركست	
-	. 4		10mm		BORM	2	35	Sm	100	- 4	20	BACT	11	200	0	2	120	
	Sta Registi		31. Date filed (Month, Day,	1 1	2007 32. Regist	rars Signa	iture	Garde.	.6									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:09 PM Josephine Alex November 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under **Funeral** Days 1 □ M 2 K F 89 Director 033-09-9251 June 2, 1918 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Md. Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 U.S.A. Funeral 3000 McComas Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ₹ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be "Unavailable" William Alex Josephine 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1101 14th Street, N.W. Suite 500 Wash.D.C.20005 Lois Hochhauser/Conservator 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 6, 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Quantico Nat'l Cem. Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licen 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Minutes Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 K No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 2 X No To the Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D64008 27/2007 30. Nam and address of person who consider cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, Md. 20910-1484 Eddie Fernandez, M.D. egistrar's Signaty 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month

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ARRINGTON

Physician /Medical **Examiner Funeral** Director 28a-f show Director Funeral

MIRIAM

"natural", or items 23a or 28a-f shov edical Examiner must be notifiled at permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural" or any injury or other traumatic event.

Physician /Medical Examiner

and the burial-trai physician use as s certificate has b funeral director

that the death certificate be executed Box 68760, Division or Vital Records, P.O. death. Director: , or / To the Hospital of within 24 hours at To the Funeral D 10)

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges
9. Birthplace (State or Foreign Country) Prince Georges General Hospital
5. Social Security Number 6. Sex 7. Age (th yrs. last Cheverly
If Under 1 Year | If Under 24 Hrs. birthday) . Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🔀 F 73 03 06 1934 110-28-5869 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1√ Yes 2 No MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9101 Second Avenue 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 ☒ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager AT&T 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lennie Arrington Mary J. Raiford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Arrington/Son 2225 Luzerna Ave. silver Spring, MD. 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Goldsboro Cremation 4 ☐ Donation 5 ☐ Other (Specify) 11-28-07 Goldsboro, NC Service 22. Name end Address of Facility 21. Signature of Funeral Service Licenses Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner CANDIUNENIC that initiated events resulting in death) Last Due to (or as e consequence of): CENTONE DC HEMONIAALE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 **1**No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Alnpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, MD

State Registra

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

D47093

29d. Date signed (Month, Day, Year)

November 18, 2007

			For State of Maryland / D State of Maryland / D Registrar	epartment of t Certificate of		, 0	iene ®g. No:?)	30600					
	Physici	an.	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	_	3. Time of Death					
mali ex	/Medic		Phyllis R. Adler			November		6:00 P. M					
	Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		or Location of Death Spring		4c. County of Dea						
-4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign ountry)					
ò	Director		Usual Residence of Decedent	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, June 19,	, 1949 Ma	ssachusetts					
	yland now at		10a. State 10b. County 10c. Cify, Town	or Location				10d. Inside City Limits					
	e Mar la-f sk	ctor	Maryland Charles Cobb	Island				1X Yes 2□ No					
	or 28	Director	10c. Street and Number	10f. Zip Code		10	0g. Citizen of What C	ŕ					
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	2062		ecify Yes or No-	U. S. A						
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Ves 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X No		Rican, etc.)	Black, Whi						
2-0	72 ho natur dical I	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occu	pation during most of work	tina I	16b. Kind of Business	s/Industry					
21215-0036	vithin "ne. han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done life. DO NOT use retire	ed)	9	Travel						
d 2	filed v Hygie other i		17. Father's Name (First, Middle, Last)	Writer	18. Mother's Nam	e (First, Middle, M							
an	lid be lental rked o	To Be	Herbert Lawrence Adler		Janet	(Unknow	vn)						
ary	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Stree	t and Number or Rui	al Route Number,	; City or Town, State,	Zip Code 20625					
Σ ()	and sealth m 27		Kirk M. Halgren - Fiance 11	950 Neale S	Sound Driv								
Baltimore, Maryland	. Pages 1 tment of H tant: If ite jury or ot		4 Donation 5 Other (Specify) Charle	Disposition (Name of crematory or other place of Mem. Gard	lens 11-2	6-07 I		n, Maryland					
Ball	permit Depar impor any in		21. Signature of Funeral Service Licensee Sorvald C. Stottlemyer	EDWARD SAC 1091 Rocky				land 20852					
2	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Breast Cancer												
X 33	/Medical Examiner		Due to (or as a consequence of):									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·):									
oʻ	tificate be executed g physician and as the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of	·):									
68760,	cate be ohysici the bu	edical	d										
P.O. Box 6	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year					
	quires that I n signed by uld be deta	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did tob		to the cause of death? Probably 4 □Unknown					
Division or Vital Records,		Completed				24a. Was ar autops perforn 1 Yes 2	y prior to						
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?		26. Place of Deat								
OL	Physi this c	ို	1	Allent SLI DOA			ence 6 Other (Sp	ecify)					
O	Attending Physician: r death. ector: After this certifics by the funeral director, I	tion		ury Wo	ork? ☐Yes 2☐No	28d. Describe no	ow injury occurred						
Divisi	af or Attending after death. I Director: After d in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1	death occurred at the formal death occurred a	time, date and place, opinion, death occur	and due to the ca red at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)					
	To the within To the comp	ž	29b. Signature and title of certifier		se number		9d. Date signed (Mor						
	2		find M Semultono		996	N	lovember 2	1, 2007					
			30. Name and address of person who completed cause of death (Item 23a) (T Linda M. Burrell, M. D. 2730 University of the Complete Cause of Complete	ersity Blvd	400,	Wheaton	, Md. 2090)2					
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 7 2007 32 registrar's Signature	Specter									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 22, 2007 Donald Eugene Andrews 6:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1710 Garden of Eden Road Cambridge Dorchester 8. Date of Birth (Month, Day, Year) Feb 18,1932 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**∑** M 2□ F Yrs. Maryland 220-26-3895 75 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2**XX**No Maryland Dorchester Directo Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1710 Garden of Eden Road 21613 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1707 es 2 □ No If Yes, Give Year or Dates 55–61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) professional engineer consulting engineer permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 is marked other tany injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Guy E. Andrews Esther Littrell ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Andrews 1710 Garden of Eden Road Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/24/07 Salisbury, Maryland 21. Signature Juneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Malignant glioblastoma Physician months disease or condition resulting in death) /Medical Due to (or sa consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a conse ruence of that the death certificate be executed the burial-trar and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9□Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 sl 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DCA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier

State Registrar

Mame and agdress of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar			land / Dep	artment of his rtificate of	dealth and	-	•	
	Physici		1. Decedent's Name (First, Midd Angela Blai						2. Date of D Month Decemb	Day	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, o	or Location of Dea		4c. County	
			3643 Churchvi	lle Road				deen		Hari	
	Funeral Director		5. Social Security Number 214–14–7260	6. Sex 1 ☐ M 2 🖫 F	7. Age (In	yrs. last birthday, Yrs.	Months Days		(Month, D	irth 17, 1922	9. Birthplace (State or Foreign Country) Maryland
	pur M	}	Usual Residence of Decedent 10a. State 10b. County	,	100	c. City, Town or L	ocation				10d. Inside City Limits
	h the Maryland r 28e-f ehow	Director	MD Ha	rford		Aberde	en			I	t X
	with the	Dire	10e. Street and Number 3643 Churchvi	lla Daad			10f. Zip Code	001		10g. Citizen of V	What Country?
	eath v	erai		12. Was De	cedent Ever	in IIS 13			Specify Yes or N		e - American Indian,
36	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow he Madical Examiner must be mullied at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ※ Widowed 4 ☐ Divorces	ried Armed F	orces? 2⊠No ive	110.3.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		rto Rican, etc.)	Blac Specify	ck, White, etc.
Ö	"naturel",		15. Deceder	nt's Education		16a. Dece	edent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry
215	hin 7.	piet	(Specify only higher Elementary/Secondary (0-12)	st grade completed	() (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo od)	orking		
21	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental the Men	Completed	12	4		Hoste	ess			Restaura	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle,							le, Maiden Suman	18)
yla	Men	ဍ	Martin Donahu						ude Kava		2 2 2 1
, Mar	and 2 sh setth and n 27 ie m er traum		19a. Informant's Name/Relation: Robert Blair				ing Address (Stree 17 Perry		Edgewood		1040
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heelth and Menta Importent: if Item 27 is marked eny Injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		n State		osition (Name of omatory or other pla Mem. Gdns		Date 6/07	Aberdee	City or Town, State
Balt	permit. Departimpo		21. Signature of Funeral Service	rania		Ta	2. Name and Address arring-Ca perdeen,	ess of Facility 1790 Fune Mary Land	ral Home	e, P.A.	
	Physician /Medical Examiner	-	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to	o or as a co	death. Do not en	iter the mode of dy		ac or respiratory		Approximate Interval Between Onset and Death
68760,45	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a co	nsequence of):					
P.O. Box 6	The law requires that the death certificate te been signed by the ettending phys age 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		birth 2 [Fetal death 3	□Ectopic pregnand □ Other (specify) _	sy .			te of delivery onth Day Year
	ires that signed b	I by Pi	Part II. Other significant condit	ions contributing to	death but no	ot resulting in the	underlying cause g	ven in Part I.		tobacco use cont	tribute to the cause of death?
of Vital Records,	e law requir hes been si je 2 should	npiete	Cerebr	ovasci	ien)	· Acc	ider		24a. We	as an 24b.	Were autopsy findings available prior to completion of cause of
E						/ 3				formed? 2 → No	death? 1 ☐ Yes 2 ☐ No
Vit	ysicien: Trisical	Be	25. Was case referred to medical examiner?	Hospital:			- 0:	h	eath (Check only		
ou of	ng Phys fter this meral di	ion; To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Dat	Inpatient of Injury onth, Day Ye	2 ER/Outpatie 28b. Time ar) Injury	of 28c. Inju	ary at ork?		sidence 6 Oth e how injury occur	
Division	o affe o	edical Certification:	3 Suicide 6 Could	miner 200. Pla	ce of Injury - ding, etc. (S	At home, farm, s	M 1 []Yes 2 □No	28f. Location City or 7	(Street and Numb own, State)	per or Rural Route Number,
_	Hospital 24 hours Funeral itely filled	licai C		ng Physician: To the		amination and/or i					anner as stated. and due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifi		I Stated		29c. Licen	se number		29d. Date signe	ed (Month, Day, Year)
	->-0		Ma	mal M	4	an	D	19582		Doggw	1600 - 200

State Registrar

Angela Mair

30. Name and address of person who completed causal of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 1 1 2007

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Morry

3. Registrar's Signature

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J	y	0		

			For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment o	of Healt	th and Math		en e (107	39613
			Decedent's Name (First, Middle, Las	t)					2. Date of Death			3. Time of Death
	Physici /Medic		Ella Mae	Brown					Month 11	11	07	10:12 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Locat	tion of Death			inty of Death	
		i.	Fort Washingt				Wash	ingto		Pri		eorges
ı	Funeral Director		230 30-1734	□M 2GJF	yrs. last birthday	Months C	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Pay, 7 13	45	9. Birth Cou Vir	place (State or Foreign intry) ginia
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	_ocation						10d. Inside City Limits
	Maryl f sho	ō	MD Prince	Georges	Oxon Hi	11						1 ☐ Yes 2 📆 No
	r 28a	Director	10e. Street and Number	Goor yes	OXOII III	10f. Zip Co	ode		10	g. Citizen	of What Cou	intry?
	th with	a D	809 Quade Stre	eet		2	0745			US	Α	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other then "neturel", or Items 23e or 28e-f show injury or other traumatic event, the Medical Examiner must be multired at injury or other traumatic event, the Medical Examiner must be multired at 8e.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13	. Was Deceden If Yes, specify			ecify Yes or No- Rican, etc.)	E	Race - Ameri Black, White, ecity: $b1$, etc.
9	72 hou	ted	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual C	occupation	most of worki	1	6b. Kind o	of Business/Ir	ndustry
21215-0036	within ene. than the Mark	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurs	DO NOT use i	retired)	most of works		lospi	i+al	
20	filed v Hygie othar t		17. Father's Name (First, Middle, Last)	17	INULS		18. M	fother's Name	(First, Middle, M			
lan	2 should be filed withir and Mental Hygiene. is markad othar than aumatic evant, Ihe M.	To Be	Sylvester Mayf	ield					Porter			
Maryland	and 2 should salth and Men n 27 is marks iar traumatic		19a. Informant's Name/Relationship (7 Elisa Brown/da	• • • • • • • • • • • • • • • • • • • •					ve Ft.			on, MD
Baltimore,	es 1 and 3 of Health fitam 27 r othar tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		0b. Place of Disp cemetery, cr	oosition (Name ematory or othe	of r place)		Date 2	0c. Locatio	on - City or T	own, State
Ĕ	Pages ment of ant: If its lury or o		* 4 □ Donation 5 □ Other (Specify)	Cedar 1	Hill C	em.	11/19	9/07 s	uitl	and,	MD
Ball	permit. Pages Department of Important: If i any injury or once.		21. Sonature of Funeral Service Licen	· Henry		22. Name and A BK Heni			Chapel	420 Wa	O H S sh, D	treet NE C 20002
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	death. Do not e	nter the mode o	f dying, sucl	h as cardiac c	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Myocard	dial I	nfarc	topn				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co Carona:		ry Di	20220					
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	cuted nd ransit	Examiner	that initiated events	c								
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):							
687	ficate g phys	edic		d								
.O. Box	that the death certific ed by the attending p detached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregi □ Other <i>(speci</i>					Date of deliv Month	very Day Year
α.	res that igned b be deta	ρ	Part II. Other significant conditions of	entributing to death but no	t resulting in the	underlying caus	e given in P	art I.				the cause of death?
orc	w requir been si should I	eted							-		- Const	bably 4 Munknown
Division of Vital Records,	The larate has	Completed							24a. Was an autopsy perform	ed?		opsy findings available ompletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		(Check only one			
of	Phys this al dir	۲ <u>.</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 KER/Outpation 28b. Time				me 5 Resider 28d. Describe hov			ify)
on	ding Ih. After funer	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yes	ar) Zob. Tille	M 200.	Injury at Work? 1 D Yes		zod. Describe rior	willing out	Surred	
Visi	or Attanding after death. Diractor: Afte in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		treet, factory, o			28f. Location (Str. City or Town,		ımber or Rur	ral Route Number,
ō	pital or urs afte aral Dir											
	To tha Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,	ledical	(Check only 2 Medical Exam	iner: On the best of my iner: On the basis of exa and manner stated.	wination and/or i	nvestigation, in	my opinion,	death occurre	ed at the time, da	te and plac	ce, and due t	to the cause(s)
	To the within To the comple	×	29b. Signature and title of certifier	la	mo		icense numb	311 ·		d. Date sig	gned (Month.	c7
,	El.		30. Name and address of person who o		(Item 23a) (Type 711 Liv	, Print)			t. Wash	207 ingt	744 Con, N	ИD
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature Space	K)						
	Registr	ar	NOV 2 7 2007	Server 1	v. po							

Amend Items 25,27,28a-f per me 8876,02/21/08dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician 23 2007 20:14 M Margaret E. November Barnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/21/1954 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🖾 F Washington, DC 53 578-76-2957 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 TXYes 2 □ No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20601 11921 Calico Woods Place USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itel other traumatic event, the Medical Examiner. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer District Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I Robert E. Pratt Izola Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrie Barnes-Herriott/Daughter 10709 Esprit Place, White Plains, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/30/2007 Brentwood, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fort, Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ adreplegio 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has b autopsy s after death.

al Director: After this certificate hated in by the funeral director, page performed 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∰ Yes 2M No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month. Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Natural Subject driver of SUV collided with a car

28f. Location (Street and Number or Rural Route Number, City or Town, State) Olson Street near 10/02/2004 10:03 a.M 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide Roadway To the Hospital or within 24 hours af To the Funeral D Raleigh Rd., Temple Hills, MD 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of c

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 2 7 2007

32. Registrar's Signature

		For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>		lental Hygie		1 33013
Physicia		1. Decedent's Name (First, Middle, Last)	E B/1	151	15		2. Date of Death Month	PR 18, 22	3. Time of Death
/Medic Examino Funeral		4a. Facility Name (If not institution, give si Hebrew Home 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	4b. City, Town, or Rockvi If Under 1 Year Months Days	Location of Death 11e If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of D Montgon 9ar) 9ar	
Director		243-36-5252 1 Usual Residence of Decedent	^{M 2}	Yrs.			April 29	,1915 V	'irginia
Marylan	lor	D. C.		, Town or Lo shingt					10d. Inside City Limits 1X☐ Yes 2 ☐ No
vith the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
ING. MAINTIBLE LICENOSO 1. and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28e-f show other traumatic event, the Medical Examinational Leandlifed at	Funeral	Tr. Marital States	Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	.0009 spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, Ihite, etc.
UU30 hours aft ural; or	þ	1 Never Married 2 Married 3X Widowed 4 Divorced	1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		1 ☐ Yes 24 ☐ No	Specify:	10	Specify: b. Kind of Busine	Black
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other than "natural, or traumatic event, the Medical Extern traumatic event, the Medical Extern	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired SE Keeper	furing most of work)		Privat	•
and A	Be	17. Father's Name (First, Middle, Last)	7	IIOu	se keepel		e (First, Middle, Ma		
and Me and Me sumatic	၉	Jean Green 19a. Informant's Name/Relationship (Typ				and Number or Run	al Route Number, C		
altimore, M mil. Pages 1 and 2 portment of Health portent: If Item 27 y injury or other tr.		Yewgenesh Lara - 20a. Method of Disposition 1 Strain 2 Cremation 3 Re	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other plac	e)	Date 20	c. Location - City	or Town, State
Editimore, permit. Pages 1 am Department of Heali Important: If Item 2 any injury or other		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22		s of Facility La	//0/ Ar tney's Fu NW, Washi		ome
PAYOU, Cate be executed /Medical Examiner bhysicien and ithe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	RY/ pence of):	ARTER	24 DI.	SEAS (5	Approximate Interval Between Onset and Death
death certifi death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
S esti	5	Part II. Other significant conditions cont SENILE DE	ributing to death but not resu $MENTIA$	ulting in the u	nderlying cause give	en in Part I.		1/	e to the cause of death?] Probably 4 □ldnknown
The law requires that the rate bas been signed by the page 2 should be delached.	Completed						24a. Was an autopsy performe	d? prior deat	e autopsy findings available to completion of cause of h? Yes 2 No
r VICAL Pysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	. 1	h (Check only one)	ce 6 ⊡Other (\$	Specify)
ing Ph Miter th		27. M numr of Death 1 V Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injun Worl	The second secon	28d. Describe how		
DIVIS saler de safter de s	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical Examin	er: On the best of my known of the basis of examinal and manner stated.		vestigation, in my of	pinion, death occur	red at the time, date	and place, and	due to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	Keloni	my	29c. License				ionth, Day, Year) FR 18, 2007
5		30. Name and address of person with con	FUMLINT	236) (Type.	612140n	TROSER	DOHO, RE	CHVILL	E 18, 2007 LEMD 2089
Stat Registra		31. Date filed (Month, Day, Year) NOV 2 7 200	32 Registrar's Signal	K A	de				

			For State Registrar	State of Ma	arylan		artment			and Me		gien: Reg. No	0007	39	616
		-1	Negistrar Nededent's Name (First, Middle, Last)	at)				, , ,			2. Date of Dea	ıth			of Death
*	Physici /Medic		LIDIYA	BULKOVSHT	EYN					1	Month Novembe	r 2	21, 2007	7:3	0 A. M
	Examin		4a. Facility Name (If not institution, give						Location of	of Death		40	c. County of Deat		
			Shady Grove Adv					kvi		O4 Uma			Montgo		
ı	Funeral Director		214-37-7866	ex 7. Age □ M 2[X]F		ast birthday) 78 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Sept.]	r. Year	r) Co	hplace (State untry) kraine	e or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	<u>.</u>	10c. City	, Town or Lo	ocation	-						10d. Inside	City Limits
	Maryl F sho	tor	Maryland Montgom	ery	De	rwood								1 X□ Y	es 2□No
	n with the 3a or 28a st be noti	Funeral Director	10e. Street and Number 16117 Crabbs Bran	ch Way, #	14		10f. Zip	Code 2085	55			10g. C	itizen of What Co	-	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced If Yes, spec	**	spanic Ori in, Mexicar Specify:	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Wh	e, etc.	
9	2 hou atura cal E	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usua	l Occupa	ation	A mel a milita	. 1	16b. l	 Kind of Business/	Industry	
21	ithin 7 ne. han "n e Medi	Completed by	(Specify only highest gra	College (1-4or 5	i+)		kind of wor DO NOT us Ceache		iuring mos !)	t of workin	g	p,	ublic Sc	hools	
Baltimore, Maryland 21215-0036	ould be filed w Mental Hygie arked other ti atic event, th	Be	17. Father's Name (<i>First, Middle, Last</i>) Toyva Kuptsin				cache				(First, Middle, Brazil	Maide			<u> </u>
ary	should and Men marke umatic	٥	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	er, City	or Town, State, 2	Zip Code)	
Σ	and 2 ealth a n 27 is		Vitaly Bulkovshte	yn-Husband		1			Brancl				erwood,		
ore	Pages 1 nent of H int: if iter iny or oth		20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐	Removal from State	20b. P	lace of Dispo emetery, crea	osition (Nam matory or o	ne of ther plac	i i		ate		Location - City or		
<u>=</u>	permit. Page Department of Important: if any injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Ju	dean M							ney, Mar		
Ba	Depa Impo any i		Donald C	Stottle		2 T	1091 R	locky	7ille	Pike	, Rock	vii	on, Inc. le, Mary	land	20852
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	ne.	ancer	ter the mode	e of dyin	g, such as	cardiac or	respiratory ar	rest,		Approxin Interval I Onset ar	nate Between nd Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):									
b		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):									
	scuted ind transit	Examiner	Cause. (Disease or injury that initiated events resulting in death) Last	C		-			_				:		
8760,	cate be executed oblysician and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	uence of):									
687	ficate physi s the b	edical		d											
Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Feta	Ideath 3	⊒Ectopic pro ⊒ Other <i>(sp</i>		,				23d. Date of de Month	ivery Day	Year
P.O.	that the de led by the a detached f		Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	bacco	use contribute to	the cause	of death?
rds	w requires that s been signed t should be det	ed by									101	es :	2 No 3 P	obably 4	Unknown
ဝ၁ခ	law re as bee 2 sho	Completed									24a. Was a		24b. Were at	topsy findin	gs available
Ž	The lav	Com									perfo	rmed? 24 N	death?		or cause or
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Tout		of Death	(Check only o	ne)			
or	aling Phys. After this of funeral directions	1.	1 ☐ Yes 2 📉 No 27. Manner of Death	Hospital: 1 Mnpatie		ER/Outpatier			4 🗀 NU		ne 5 Resid		6 □Other (Spe	cify)	
on	Attending Physician: r death. ector: After this certifica by the funeral director, i	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	M	8c. Injun Worl 1 □ `	k? Yes 2□			1011 111	ary occurred		
Division or Vital Records,	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injusting, et	ury - At ho c. (Specify	ome, farm, st	reet, factory	, office		2	8f. Location (S City or Tow	Street a	and Number or R	ural Route N	lumber,
		Medical C		ysician: To the best niner: On the basis o and manner sta	f examina										se(s)
	To the within To the comple	Me	29b. Signature and title of certifier			*	29c	. License	e number				ate signed (Mont		
)	V		9					5	185	97		No	vember 2	21, 20	07
			30. Name and address of person who Dr. Shahryar Dav		eath (Item 5 Sha	123a) (Type, 1dy Gro	Print) ove Ro	oad,	Suit	e # 2	208, Ro	ckv	ille, Ma	l. 208	50
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr			- MF a								

Registrar

NOV 2 7 2007

		_	State Registrar		•	ificate of L			Reg. No?	107	39618
46. \$6	Physicia	56	1. Decedent's Name (First, Middle, Last) Margaret J. Berg	<u>></u>				2. Date of Demonstration Month Novembe	Day _	2007	3. Time of Death 4:46 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and nu	mber)		4b. City, Town, or			4c. Cour	nty of Death	
-			Shady Grove Adventist Ho 5. Social Security Number 6. Sex	ospital 7. Age (In yrs. last b	hirthday)	Rocks	rille If Under 24 Hrs.	8. Date of Birt		1tgome	ry place (State or Foreign
	Funeral Director		075-12-1134 Usual Residence of Decedent	86	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da March	y, Year) 22 , 192	Coui	Jersey
	yland now at		10a. State 10b. County	10c. City, To	wn or Loc	ation				1	10d. Inside City Limits
	ie Mar Ba-f sl	Director	MD Montgomery		C1	arksburg					1 □Yes 2 No
	h with th	al Dire	10e. Street and Number 13120 Cool Brook Lane			10f. Zip Code 2087	L	1	10g. Citizen o United		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Dec Armed For 1 Yes, Gir Year or Divorced	2 X No ve No		ras Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Е	Race - Americ Black, White, ecify: Wh	etc.
150	n 72 hc "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa ind of work done of O NOT use retired	luring most of worl	king	16b. Kind of	f Business/In	ndustry
212	d withi glene. er than the M	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Reco	rd Keepei	c		Bank	ing	
Maryland 21215-0036	uld be file fental Hy rked othe tic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) John Niznansky				18. Mother's Nam Kristin	ne (First, Middle, na Nizna		name)	
	and 2 should bath and Meni alth and Meni 27 is marked er traumatic		19a. Informant's Name/Relationship (Type. Print) Richard Berg / Son	1	.7087	Address (Street a	Le Road ,				o Code)
Baltimore,	Pages 1 ament of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place cemer Metrs	of Dispose tery, cremonali crema	ition (Name of atory or other plac tan tory	Nove 26	ember 2007		on - City or Tondria,	own, State Virginia
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lipensee TRACA Stude			Name and Addres		Burg, E	B ^t 2887	7 Parl	k Drive,
	Physician	6 -	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or conditiona.	Cardiac A	rryt		g, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death Minutes
	/Medical Examiner			(or as a consequence Respirato		dilure					1 Day
	P #	ner	Sequentially list conditions, and to cause. Enter Underlying Cause (Disease or injury that initiated events	or as a conse ueno				7			2 h1 F
þ	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	Septicemi (or as a consequence		-++		X	1	tw 1) 1 [
68760,	tificate be executed ig physician and as the burial-transit	ledical E	d	Clostridi	um d	iffcile	colitis	1/1	Er Ja	11	607
P.O. Box (The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	atcome pf pregnancy birth 2 □ Fetal dea nant at time of death nown	ath 3 🗌	Ectopic pregnancy Other (specify)	K.		23d.	Date deliv Month	very Day Year
rds, P	juires that n signed b ild be deta	þ	Part II. Other significant conditions contributing to d Acute Renal Failure,								the cause of death? bably 4 [XUnknown
Division or Vital Records,	The law rec te has beer age 2 shou	Completed	Pelvic Fracture					24a. Was auto perfo	an 24 psy ormed? 2 \(\subseteq No	4b. Were aut prior to co death? 1 ☐ Yes	copsy findings available completion of cause of
ital	ilan; T	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
ار د	Physic this ce al dire	은	1 X Yes 2 No Hospital: 1 X	Inpatient 2 ER/O		3 DOA Oth	er: 4□ Nursing H	lome 5 Res	idence 6 🗆	Other (Spec	ify)
ono	ding F h. After funera	tion:	1 Natural 5 Pending (Mon	nth. Dav Year)	Injury 100 J	28c. Injur Worl D M 1 □	yat k? Yes 2.[X]No	28d. Describe		currea	
Divisi	l or Atten after deat Director:	Certification:	3 Suicide 6 Could not be 28e. Plac	e of injury - At home, ding, etc. (Specify)		et, factory, office				umberor Rui Clarks Cook L	burg, MD 20
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and mai	e best of my knowled basis of examination nner stated.	dge, death and/or inv	occurred at the tir restigation, in my o	me, date and place opinion, death occu	e, and due to the	cause(s) and	d manner as	stated.
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens			29d. Date si		
	D		May			DO	0644	78	Novem	ber 21	2007
	1.		30. Name and address of person who completed cau Fisehatsion Mehari, M.D				Drive,	Rockvil:	le, MD	20850	
	Sta Registi			Registrar's Signature					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.Z U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 23, 2007 **Physician** 6:00 PM Eva Elizabeth Butler ovember /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Prince alver Frederick LOUNTY Lenter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Ade (In vrs. last birthday **Funeral** Days Months Hours Min, 1 □ M 25 € Director 218-24-6200 81 MD Jul 28, 1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Dowel MD Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20629 U.S.A 249 Newtown Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🗷 No Specify Specify: Black 3 □ Widowed 4 □ Divorced Year or Dates: Completed f Health and Mental Hygiene.
Item 27 is marked other than "natur
other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government Housekeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Kyler William Harrod P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 249 Newtown Road Dowell, MD 20629 Levi Butler /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/01/07 St. Leonard, MD Brooks UMC Cemetery Signature of Funeral Service License 22. Name and Address of Facility Gladep Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a ornsequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed ed by the attending physician and detached for use as the bunal-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I 2 No 9 ☐ Unknowń signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 pe 20 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' autopsy performed? page After this certificate 2 No Vital 1□ Yes 2 **N**0 1 ☐ Yes or Attending Physician: 25. Was case referred to medical ector, Be 26. Place of Death (Check only one) examiner' Other: 24Z No ဥ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 □ DOA ŧ W☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury thin 24 hours after death.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 2

drw 10

DHMH 17 Rev 1/2001

Registrar

of person

30. Name and address

31. Date filed (Month, Day,

20628

completed cause of death (Item 23a) (Type, Print)

32. Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Joseph Harry 25, Nov. 2007 11:59 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5535 White Hall Road Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 8,1922 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months 85 154-16-3517 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Cambridge Director Maryland Dorchester death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5535 White Hall Road 21613 or Items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced "naturel", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Air Pollution al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vice President Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linty or other traumatic event 2015. Be Harry Joseph Barr Margaret Theresa Spielle ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Severn Avenue, #204, Annapolis MD 21403 Briget Barr/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Good Counsel 11/30/2007 Secretary, MD 21. Signature of Feneral Service Licensee 22 Name and Address of Facility eller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 231. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrovascular **Physician** /Medical Due to (or as a consequence of) Examiner ial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physicien and the for use as the burial-transit rostate Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 1No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ၉ 1 Tyes 2 **(3**4%) 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Director: After 1 Vatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ENIOUM.D 00057040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE PALTOO 195 AURORA BRENDON MD 31. Date filed (Month, Day, Year) 32. State NOV 2 8 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 305 am awrence November 23, 200 olden nwood /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Jaryand General reltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 68 214.36.5263 Usual Residence of Decedent Yrs. 15,1939 Director Marylano 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show Examiner must be notified at 1 Ves 2 No Director ambridge the th 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with Avenue KuseMont Funeral death 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 212 No Specify: ģ Specify: Black 3 Widowed 4 Divorced 1962 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Maintenance Worker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brooks Horace MarJorie ပ Bolden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Cambridge, Mary land 216 13

Date 20c. Location - City or Town, State Bolden 720 Marion Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 3/07 4 □ Donation 5 □ Other (Specify) Veterans Hurlock, MD. 22. Name and Address Facility
12. Name and Address Facility
14 ENRY Funeral Home, P.A.
15 10 Washington St. Cambridge, M.D. 21613
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Approximate 21. Signature_of Funeral Service Licensee 23a. Part1. In the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) table Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed neumonia Ketractory physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the as attending l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director:
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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sroude

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2007

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Alice G. Conner 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Cheverly Prince George Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 ☐ M 2 💢 F 77 Director May 14,1930 Virginia 225-36-4892 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. VA. Emporia 1 ☐ Yes 🏋 ☐ No Director Greensville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23847 U.S.A. 395 Dahlia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2X Mamied 1 ☐ Yes 2 😾 No Specify. Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Sumler ဂ္ Williamson Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 395 Dahlia Rd.,Emporia,VA.23847 William Conner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Antioch Bapt.Ch.Cem. 11-26-07 Skipper, VA. 22. Name and Address of Facility Knox-High Mortuary, INC 21. Signature of Funeral Service Licensee 568 Halifax St., Emporia, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (Cas a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş HTN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1☐ Yes 2XNo funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

altimore, Maryland 21215-0036

within 24 hor To the Fune

DHMH 17 Rev 1/2001

To the

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 2 6 2007

29b. Signature and little

29a. Certifier

100 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSP

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Dav. Year)

20

heverly MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 24, 2007 Margaret Chura A M 9:53 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Laurel Healthcare & Rehab. Laure1 Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 171-32-9578 1 □ M 2√□ F 66 1940 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Director Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be 35 Old Solomons Island Road 20711 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) Secretary Agriculture marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H Stephen Basista Anna Bendzalla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an S Bryan Chura-(Son) 35 Old Solomons Island Road, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Bernards
Cemetery it. Pages 1
artment of P
ortant; If ite 20a. Method of Disposition 20c. Location - City or Town, State November 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or 26, 2007 4 Donation 5 Other (Specify Hastings, PA 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service Livens 10 E. Deer Park Drive, Gaithersburg, MD 20877 or complications that caused the death. Do lot enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part . Enter the disease should, or in higher. Approximate Interval Between Onset and Death Immediat Cause (Fmal disease or monor ion resulting in death) Physician Congestive Heart Failure 1 week /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit be executed Due to (or as a consequence of) physician Box 68760 Physician/Medical for use as attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 5 Other (specify) P.O. | ed by the a detached for 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has page 2 1∐ Yes 2XNo Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 XNatural To the Hospital or Attendit
 within 24 hours after death.
 To the Funeral Director; All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Danny Lee, M.D., 8317
31. Date filed (Month, Day, Year)
NOV 2 7 2007

Cherry Lane,

29c. License number

Laurel, Maryland 20707

29d. Date signed (Month) Day, Year)

			State State	of Maryland / De	epartment of H Certificate of I		277		
			1. Decedent's Name (First, Middle, Last)				Reg. N	2007	3 Tiple 602th
	Physici	an	David Bruce Colby				Nov.	o, 2007	4:00 p M
Jane 1	/Medic Examin		4a. Facility Name (If not institution, give street and r 2608 Chapel Lake Driv			Location of Death	4	c. County of Death Anne Aru	ndel
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birtho	I Months Davs	Hours Min	B. Date of Birth (Month, Day, Yea May 1, 19	r) 9. Birthp Cour	olace (State or Foreign otry)
	pug 🔥		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			1	0d. Inside City Limits
	Maryla f sho	tor	MD Anne Arundel		Gambri	ills			1 ∐Yes 2 X No
	with the 3a or 28a	I Direc	10e. Street and Number 2608 Chapel Lake Driv	re	10f. Zip Code	1054	10g. C	Citizen of What Cour	ntry? USA
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2	72 hou natura Jical E	eted	15. Decedent's Education (Specify only highest grade complete	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of working	16b.	Kind of Business/In	dustry
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, Maryland	and 2 sho salth and 1 27 is mu er traum		19a. Informant's Name/Relationship (Type. Print) Judith Colby/Wife	26	Mailing Address (Street 108 Chapel	Lake Drive	, #404, G	ambrills,	MD 21054
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	Funeral		Glade Valley No. 5. Social Security Number	6. Sex		rs. last birthday,	If Under 1 Y	ear If Unde	er 24 Hrs.	8. Date of Bir	th Voar	9. Birtl	nplace (State or Foreign	n
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and	be filed withil tal Hygiene. d other than event, the M	Be	17. Father's Name (First, Middle,	Last)				18. Moti	ther's Name	(First, Middle	, Maiden	Surname)		
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Mar	2 should be and Menta Is marked raumatic ev		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mail	ing Address (St	reet and Num	ber or Rura	al Route Numb	er, City o	r Town, State, Z	(ip Code)	
2`	12 # d		William C. Col	lins, Hu	usband		vlvia Ci	ircle .		nont, M			788	_
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g	permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funeral Service	Ligensee			22. Name and A		Sta				es, P.A.	
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5	the a	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Preg 9□Unk	gnant at time on the contract of the contract	of death 5	Other (specif	(y)					54,	
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	To the Hospital or Attending Privithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral privity.	Medical	one)	and ma	anner stated.									
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	N		30. Name and address of person	who completed car	use of death (I	Item 23a) (Type	Print)	. Dan De	600	AIT.	1.	00		
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	Registr		NOV 2.8	2007	6	K D	rade							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39630 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician DECEMBER DOUGHERTY ALLEN 8:45A EUGENE 4,2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **X** M 2 □ F Ohio 78 Director 281-22-0700 February13,1929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Franklin Grove City Director Ohio 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3745 Alkire Road 43123 U.S.A. 2 should be filed within 72 hours after death on and Mental Hygiene.

Is marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Distribution 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Palmer William Dougherty 2 Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 | Martita Dougherty/Daughter 3206Kenny Road, Columbus, Ohio 43221 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Columbus, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 12-10-07 Alton Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or all a conse wence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s autopsy performed' director. 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Perfitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the 1

> State Registrar

29b. Signature and title of certifier

30 Name and addre

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

rapleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		rtment of H tificate of L		lental Hy	giene Reg. No2 (107	39631
	Physicia /Medic	-	1. Decedent's Name (First, Middle, La Mary Ellen	Dolbeare				2. Date of Dea Month NOV •	ath 21 , 200)7 Year	3. Time of Death 8:00 P M
	Examin Funeral			opal Life Care ing Home Sex 7. Age (In yrs. I	-		ellville If Under 24 Hrs. Hours Min.	8. Date of Birt	h y, Year)	9. Birthp	George's
	Director		Usual Residence of Decedent	89	Yrs.			Jan. 2	7, 1918	New	York
	Marylan -f show fied at	tor	10a. State 10b. County Maryland Prince		y, Town or Loc Mitche	ation				1	10d. Inside City Limits 1 Yes 2 No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	eath w	eral	10450 Lottsford 11. Marital Status	Road 12. Was Decedent Ever in U.	S 13 V		721	ecify Yes or No	USA 14. B	ace - Americ	can Indian.
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba	spanic Origin? (Spanic Mexican, Puerto Specify:	Rican, etc.)		lack, White,	
0-017	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of work)	ing	16b. Kind of	Business/In	dustry
7	led wil lygien her tha	Con		4	Perso	nnel Adm	inistrato 18. Mother's Name			d Nati	Lons
aud	d be fi	o Be	17. Father's Name (First, Middle, Las Louis Urban Dolb				Caroline			· ·	<u>-</u>
ary	shoule and Me s mark umatic	To	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a	and Number or Run				
e, Z	and 2 ealth a n 27 ls		Niles Dolbeare -				Point Ri			4807	
1016	ages 1 nt of H : If Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 】	Hemoval from State		sition (Name of natory or other place	1 .	Date	20c. Location	-	
Dallimor	nit. Partmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service, Lice			n Uremato . Name and Addres	ory 11/2 as of Facility	8/0/			Virginia more Ave.
ŏ	Dep Imp any		Pernest	& Colina	Andrew .					sville	e, MD 20781
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List onf Immediate Cause (Final disease or condition resulting in death)	volications that caused the death y one cause on each line. a. Alzheimers			g, such as cardiac	or respiratory a	rrest,]	Approximate Interval Between Onset and Death O years
	/Medical Examiner			Due to (or as a consequent	uence of):						
6.	cuted and and and and and and and and and an	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a consequence.	uence of):					~	
00/00	ificate be executed physician and st the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	uence of):						
T			IF FEMALE:			en contractor on the					
.O. Box	siclan: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 □	Ectopic pregnancy Other (specify)	,			Date of deliv Month	ery Day Year
ecords, P	quires that n signed by uld be deta	by	Part II. Other significant conditions	contributing to death but not rest	ulting in the ur	nderlying cause give	en in Part I.	23e. Did t			the cause of death?
Ē	The law reate has bee page 2 sho	Completed						24a. Was autor perfo		prior to co death?	opsy findings available ompletion of cause of
	iclan: sertifica ector, p	Be C	25. Was case referred to medical examiner?	Hagnital		Tout-	26. Place of Deat				
0	r Attending Physician: The isr death. rector: After this certificate haby the funeral director, page by the funeral director, page	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of		4 KEN NUTSING HO	ome 5 Residence 28d. Describe			fy)
0	ath. rr: Afte	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2∐No				
SINI	<u>0</u> € 5 5	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ome, farm, stro	eet, factory, office		28f. Location (City or To		mber or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (Physician: To the best of my kno aminer: On the basis of examina and manner stated.							
ı		Me	29b. Signature and title of certifier	M NO	·	29c. Licenso D4 7	e number '603		29d. Date sig 11/26		Day, Year)
	503		30. Name and address of person who William Duboyco				chellvill	e, MD	20721		
	Sta Registr		NOV 2 6 2007	32. Registrar's Signa		-					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:35A™ Dobbins 11/21/2007 В. Ethel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs. 10/27/1913 Virginia 223-38-6415 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. 9m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County sa or 28a-f sh t be notified a 1√E¥es 2 No Funeral Director Blacksburg VA Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 403 Jackson St. 24060 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. "natural", or iten 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Bell Alice Brown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20th St. N.E. Washington DC 20018
tion (Name of Date 20c. Location - City or Town, State of Health item 27 Rice Dobbins Sr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H.
Important: If iter
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Blacksburg Cem. 4 ☐ Donation 5 ☐ Other (Specify) 11/27/2007 Blacksburg VA 22. Name and Address of Facility 21. Signatur of Funeral Service Licenses Dunn&Sons 5635 Eads St.NE Wash?hgt8n,DC · Inderes 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventrula tachycondu /Medical Due to (or as a consequence of): Examiner caratemy on a file to (or as a consequence of): (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed the burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 Tes 2 No 3 Probably 4 Unknown cardiac arrest Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 2 No 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗖 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident after death Director; filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 6 within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D63183 normal MID 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 7503 SURRATTS SHRI KANNAN ROAD CLIMPON 32. Registrar's Signature State Registrar

			For State Registrer		State	of Marylar		artmen rtificate			and M	lental Hy	giene Reg. No.	2007	39633
	Physici		1. Decedent's Name Helen Ell		•	·						2. Date of De Month Novembe	Day	Year 2007	3. Time of Death 7:41AM
	/Medic Examin		4a. Facility Name (If I	not institution, g	ive street and n	umber)				Location o		MOVEINDE	4c. (County of Dea	ath
			6532 Pine 5. Social Security Nui		ad	7. Age (In yrs.	last highdayl	Hur]		If Under:	24 Hrs.	8 Date of Bi		rchest	
	Funeral Director		213-24-436		1□M 2፟MF	80		Months		Hours	Min.	8. Date of Bi (Month, Di Sept.	ay, Year) 3.192	7 New	rthplace (State or Foreign Country) Jersey
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80	with the a or 28s	Funeral Director	10e. Street and Numl		o d			10f. Zip	Code 21643)				en of What C	country?
to	leath	era	6532 Pine	Tob Kc		cedent Ever in U	J.S. 13.				gin? (Sp	ecify Yes or N			nencan Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f show eny injury or other traumatic event, the Medical Experient mast be notified at once.	by Fun	1 Never Marrie	_	Armed F 1 1 Yes If Yes, G Year or	2 X No Sive		lfYes, spec 1 ☐ Yes			i, Puerto	ecify Yes or N Rican, etc.)		Black, Wh Specify: W	ite, etc. hite
21215-0036	2 hou	ted		15. Decedent's	Education		16a. Dece	dent's Usua	l Occupa	ation			16b. Kir	nd of Busines	s/Industry
215	hin 7.	Completed	(Specify Elementary/Second		grade completed College	(1-4or 5+)	life.	kind of wor DO NOT us	e retired	<i>during</i> mosi)	t of work	ing	Clot	hing	
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Maryland	uld be filk Aental Hy rked oth tilc even	e e	17. Father's Name <i>(F</i> Raleigh Ge									e (First, Middle E11en			
Mary	od 2 sho lith and ! 27 is ma		19a. Informant's Nar John E. D					•				al Route Numb			
Baltimore,	of Hea		20a. Method of Dispo	osition		I .	Place of Dispo cemetery, crei	sition (Nan	ne of	е)	_	Date	20c. Loc	cation - City o	r Town, State
Ë	Pag tment tant: jury c		4 Donation 5	Other (Spe	city)		Veteran		_			1/2007			
Ball	Depar Depar Impor eny in	1	21. Signature of Fun	eral Service bio	ensee	Eller	Z_{10}^{22}	2.Name an 211er 06 Mai	fune Fune n St	ss of Facilit eral treet	y Home , Ea	, P. O.	Box Mark	207 et, MD	21631
3760,	Physician Personned State of the Physician Physician and State of the Physician and Lorenze as the privial-transit	Ical Examiner	Immediate Cause (F disease or condition resulting in death) Sequentially list condition if any, leading to limit cause. Enter Underl Cause (Disease or in that initiated events resulting in death) La	ditions, neciate ying njury	b. Due to	o (or as a conse	quence of):	fil	pro	s/s					Onset and Death IO YESS
P.O. Box 68	requires that the death certifica een signed by the ettending ph hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nopths?	1 ☐ Līve	outcome of pregrebith 2 Fet gnant at time of unown	al death 3	∃Ectopic pr ∃ Other (sp					2	3d. Date of d Month	elivery Day Year
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Recor	aw Is b	Completed										24a. Wa auto		24b. Were a prior to death?	autopsy findings available completion of cause of
<u>=</u>	Page 4											1 Yes	2 No		es 2 No
×.	Physicien: this certificated director.	Be	25. Was case referred examiner?	_	Hospital:	74	7500		Oth	05		h (Check only			
Division of Vital Records,	ing Pt After th funerel	tion: To	1 Yes 2 TA 27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Dat (Mo	Inpatient 2 [e of Injury onth, Day Year)	28b. Time o Injury		8c. Injun Worl	4 LINU		28d. Describe			өслү)
Divisi	t or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 4 Homicide	6 Could no determin	t bo	ce of Injury - At I Iding, etc. (Spec	nome, farm, st ify)	reet, factor	, office			28f. Location City or To	(Street and own, State)	d Number or I	Rural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Certifying		he best of my kn basis of examin anner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s) , date and	and manner a place, and di	as stated. ue to the cause(s)
_	To the within 2 To the complex	Me	29b. Signature and t	itle of certifier						e number				-/	nth, Day, Year)
	> - 0		· AG	adne	ion i	DU			Ho	039	79	73	//	1/19/	7
			30. Name and lighte	ss of person when the state of	no completed ca	use of death (Ite	m 23a) (Type. m 6/c	Print)	. (Cam	br	idge	MI	2	
	Sta Registr		31. Date filed (Month			Registrar's Sign	ature	Son	80						

			For State		n wat yla		tificate of l	lealth and M Death			0.7	00001
			Registrar 1. Decedent's Name (First, Middle, Las	st)			imeate of i		2. Date of Dea	eg. No. 2	U /	3. Time of Death
	Physicia	_	Margarat Maris Di	con					Month Novembe	Day	Year	7:55 P ^M
	/Medic Examin		Margaret Mary Du 4a. Facility Name (If not institution, give		ımber)		4b. City, Town, or	Location of Death	Novembe		y of Death	7.55 F
	Examin	er	34 Ulmer Lane		,		North	_		Ce	ci1	
ic ne	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yr.	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Director		215-54-1869	□M 2 X)F	5.	5 Yrs.	Months Days	Hours Min.	July 3,		Ma	aryland
	D		Usual Residence of Decedent					1	, j j			
	irylar show	_	10a. State 10b. County		10c. 0	City, Town or Lo	cation				11	0d. Inside City Limits
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	ਜ਼ੈ ਦੇ 8 ਰੂ 10 ਰੂ	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	itry?
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	er de	Funeral	11. Marital Status	Armed Fo		U.S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Amenc ick, White,	
0	s aft	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Gi Year or D	ive		I ☐ Yes 2 💢 No	Specify:		Speci	fy:	
3	hour al Es	ed k	15. Decedent's Ed		outes.	16a. Deced	lent's Usual Occup	ation		16b. Kind of E		ite
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7	with liene.	Completed	Elementary/Secondary (0-12)	College ((1-40r 5+)	Custom	er Servi	ce Repres	entative	e Socia	ıl Ser	vice
2	Hyg Other ent,	Be C	17. Father's Name (First, Middle, Last,)		,		18. Mother's Nam				
2	lid be lenta ked ked itc ev	To B	Joseph B. Dugan					Lillia	n Ryan			
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, and Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at							and Number or Rui	ral Route Numbe	r, City or Town	, State, Zip	Code)
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ָב ע	permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Fages 1 and 2 should be filed within 72 hours after 23a or 28a-f show Important; if fem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	In		. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	own, State
₫ .			1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specif</i>			· ·	w Cemeter	1	5-2007	Rising	Sun,	Maryland
	rmit.		21. Signature of Funeral Service Lice	isée		22	. Name and Addre	ss of Facility rd Funera	1 Uomo	ъΛ		
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F	Physician		Immediate use (Final disease condition resulting in death)			- 61m	non	30.00				Onset and Death
	/Medical		resultive in death)		(or as a cons			11/20/2				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HARLES WALTER NOVEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE BURNIE WASHINGTON MEDICAL (ENTER GLEN ARUNDEL If Under 1 Year Days Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1**X** M 2□ F Min Months Hours Director 579-58-1816 Dec. 24, 1943 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No MD Director Anne Arundel Co. Odenton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 929 Nanticoke Run Way U.S.A. 21113 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced "natural" Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Safety Officer Architectural Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline R. Barrett ပ္ Charles Walter Eaton. Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 929 Nanticoke Run Way, Odenton, Maryland 21113 Charles W. Eaton, III. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 29 Important: If it any injury or c 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Lee Crematory Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fun 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician NFARCTION 24105 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOVISCULAR ATHEROXLOROTIC Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed peen HEART FAILURS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No UNGESTIVE has je 2 autopsy page performe this certificate 2 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

drw

State Registrar

10mis 31. Date filed (Month, Day

1417 AYALA 32. Registra Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADISON

6LEN BURNIE

NOVEMBER

ZiO7

ds, P.O. Box 68760,		Baltimore, Maryland 21215-0036
lires that the death certificate be executed	Ph //\ Ex	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
signed by the attending physician and	ysic Ned ami	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show

			1 _ State	e of Maryland / De	partment of F Certificate of			ene 2007	39636		
			Registrar 1. Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death		
1	Physicia /Medic		JOSEPH	ETTIN			(1	24 07			
1	Examin	er	4a. Facility Name (If not institution, give street and 2542 Sandy Run Court	d number)	Annapol	r Location of Death Lis		4c! County of Dea Anne Aru			
5.	Funeral Director		5. Social Security Number 114-03-8881 6. \$\frac{1}{2} \text{M} 2	F 91 Yrs	Months Davs	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 17,1	9. Bir New	thplace (State or Foreign Durty) York		
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits		
	e Mary a-f sho tified a	ctor	MD Anne Arundel	Annapol:	Ĺs				1 □ Yes 2 XXNo		
	th with the 23a or 28 ast be no	Funeral Director	10e. Street and Number 2542 Sandy Run Court		10f. Zip Code 2140]	L	10	g. Citizen of What Co USA	ountry?		
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funer	1 □ Never Married 2 □ Married	Decedent Ever in U.S. d Forces? /es 2 ☐ No s, Give or Dates: WWII	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
21215-0036			ompleted	ompleted	ompleted	ompleted	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)	ted) 16a. De (G (G (li)	ecedent's Usual Occup Rive kind of work done fe. DO NOT use retire Attorney	oation during most of worki d)	ing 1
Maryland 2	uld be filed fental Hyg rked other ric event, i	To Be Co	17. Father's Name (First, Middle, Last)	Ettinger		18. Mother's Name Sara	e (First, Middle, M	aiden Surname) Gorlachek	,		
lary	s 1 and 2 shou of Health and M item 27 Is mar other traumat		19a. Informant's Name/Relationship (Type. Print)		lailing Address (Street				Zip Code)		
			Blanche Ettinger Wif 20a. Method of Disposition	20b. Place of D	2 Sandy Run isposition (Name of crematory or other place			s,MD 21401 Oc. Location - City or	Town, State		
Baltimore,	Pages ment of ant: If i ury or		1 ABurial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 □ Other (Specify)	Wellwood	d Cemetery	11/26	5/07 1	Farmingdal	e,NY		
Balt	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Annapolis, MD									
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause immediate Cause (Final	hat caused the death. Do not on each line.	enter the mode of dyi	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition aa.	e to (or as a consequence of):					Sylar		
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	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o to (or as a sonsequence or).							
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Vital	Physician: The this certificate rat director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 inpatient 2 ER/Outpa	atient 3 DOA Oth	or.	h (Check only one	nce 6 Other (Spe	ecify)		
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Division	al or Atter after dea' I Director d in by the	Certification:	3 Suicide 6 Could not be 28e. I	Place of injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Str City or Town	eet and Number or F State)	Bural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, of the basis of examination and/of manners stated.	death occurred at the ti or investigation, in my	me, date and place, opinion, death occur	and due to the ca	use(s) and manner a ate and place, and du	as stated. ue to the cause(s)		
	withii voint	ME	29h Sionature and title of certifier	Tenta un	29c. Licens	21438	29	Od. Date signed (Mon	oth, Day, Year)		
,	NOW P		30. Name and address of person who completed MICHAEL - GIEN	cause of death (Item 23a) (Ty	(pe, Print)	E 176+	tWAy F	INNAPOU	SMD21401		
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		State of Maryland 1- State Registrar	/ Departme				ntal Hyو ا	giene	2007	39637
Physic	on	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
Physici /Medi	cal	13ary D. Elsasser	4h Cii	y Town o	or Location	n of Death	11	23		チ 시 ""
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 F 55	st birthday) If Und Month	er 1 Year s Days	If Unde Hours	Min.	Month, Day	y, Year)	9. Bir	thplace (State or Foreign ountry) PA
Director		Usual Residence of Decedent				FL	AY 6,	1932		
arylan show d at	ř		Town or Location FREDRIC	שר						10d. Inside City Limits 1 ☐ Yes 2 No
the M 28a-f notifie	Director	MD FREDRICK 10e. Street and Number		Zip Code				10g. Citiz	en of What C	
th with 23a or ist be	al Di	/108 LINGANORE ROAD		217	01			U	.S.A.	
21215-0036 I within 72 hours after death with the Maryland liene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	. 13. Was Der If Yes, s 1 ☐ Yes	cedent of Hoecify Cub		Origin? (Speci can, Puerto Ri fy:	ify Yes or No- ican, etc.)		4. Race - Ame Black, Whi Specify:	
15-0	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U (Give kind of life. DO NOT	sual Occup	pation during m	ost of working	7	16b. Kir	nd of Business	/Industry
d 2121 filled within Hygiene. wher than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5 +	ELECOMMU				I	1	UNITED GOVI	STATES
ind 2 be filed that the filed of other dother event, the	8 B	17. Father's Name (First, Middle, Last)				ther's Name (Maiden	Surname)	
Maryland d 2 should be file th and Mental H 7 is marked oth traumatic event	2	ALFRED C. ELSASSER 19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Addre	es (Street		TH HEI		er City or	Town State	Zin Code)
_ c = 0 =		KATHERINE R. ELSASSER/DAUGHTER	•	•						NY 10009
of H of H of H		1 XBurial 2 □ Cremation 3 □ Removal from State	nce of Disposition (Nametery, crematory of	r other pla	· i	Da			cation - City or	
Baltimo		4 □ Donation 5 □ Other (Specify) GRAC 21. Signature of Funeral Service Licensee	22. Name	and Addre	ess of Fac	cility	- 539-111		NEW CAS	STLE, DE
any me me		M00840	SPICE 1000	R-MUL N. DU	LIKI PONT	N FUNE PKWY.	RAL HO NEW	MES CAST	LE, DE	19720
		23a. Part1. Enter the disease, or complications that caused the death. shock, othear failure. List only one cause on each line.	Do not enter the m	ode of dyi	ing, such	as cardiac or	respiratory a	rrest,	,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the conse	of feeture	1 21	(0)	yound y	Lobert	MWC	M4_	One week
Examiner		throng a	Cudul	200	thru					one welk
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):							
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58 760, ficate be executed physician and s the burial-transit	Physician/Medical E									
			cv						3d. Date of de	livery
the check		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	death 3 □Ectopic		су				Month	Day Year
res that signed by be deta	by	The state of the s	ting in the underlyin	g cause giv	ven in Pa	rt I.			se contribute	o the cause of death?
Hecords, The law requires t e has been signe age 2 should be c	Completed	They tay was					24a. Was			utopsy findings available
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Or \ Physic rthis c ral dire	ု	1 Yes 2 No Hospital 1 → Impatient 2 E	R/Outpatient 3 28b. Time of	DUA			e 5 🗆 Resi		Other (Sp.	ecify)
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DIVISION OF II or Attending Physafter death. Director: After this in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, fac	ory, office		28	3f. Location (City or To	Street and wn, State	d Number or F)	Rural Route Number,
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.										
o the Pithin 24	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licen						nth, Day, Year)
F 3 F 8		m. Rayol & Min		200	54	139		1111	407	
(VI)		30. Name and address of person who completed cause of death (Item 3)		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	01.	120 2	. 0	2/2	Cha. M	20832
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		10	1 1	MY W	Klar.	~ r (7 1 11	2 5000
Regist	rar	NUV 2 6 2007 Heren	15 HOW							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** FOOKS JOY DELIGHT 26 12:30 PM NOV. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of maryland Medical Center NIA Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 X F Months Days Director 214-66-8367 DECEMBER 19, 1954 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐ Yes 2 X No MARYLAND QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 5132 MAIN STREET 21638 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ★ Married Maryland 21215-0036 1 ☐ Yes 2 📆 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME HEALTHCARE PROVIDER 12 SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant; If Item 27 is marked ott CHARLES HARRIS ANITA HUGHES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES FOOKS/HUSBAND 5132 MAIN STREET, GRASONVILLE, MARYLAND 21638 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o NOVEMBER 28 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dther (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Funer Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Anoxic disease or condition resulting in death) brain injury 2 weeks /Medical Due to (or as a consequence of): Examiner weeks paricreatitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed 2 weeks attending physician and for use as the burial-tran septic shock Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ARDS 2 weeks IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy signed by the atte in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 No 2**⊠**No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A r filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1386847903

State Registrar 31. Date filed (Month, Day, Year) 2007 NOV 27

Catherine Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Greene St. Baltimore, MD 21201 22 sistrar's Signature

M.D.

Nov. 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOV. 2007 1256 \mathbf{P}^{M} SHIRLEY BOYD FLETCHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT **EASTON** MEMORIAL HOSPITAL AT EASTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 📉 69 WEST VIRGINIA Director 235-54-6558 MAY 4, 1938 Usual Residence of Decedent be filed within 72 hours after death with the Maryland trat Hyglene.
ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director **QUEEN ANNE'S** STEVENSVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21666 USA 908 MONROE MANOR ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TOWING/AUTOMOTIVE BOOKKEEPER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil timent of Health and Mental H tant: if item 27 is marked oth jury or other traumatic even Be SIMPSON F. BOYD PEARL MATTHEWS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 MONROE MANOR ROAD, STEVENSVILLE, MD 21666 SHELIA STAIRS/ DAUGHTER Baltimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 11-25-2007 STEVENSVILLE, MD 21666 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1 Enter the disease shock, or heart failure. Lis nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Imm ate Cause (Final EMDYEMO **Physician** 100/5 disease or condition resulting in death) /Medical Due to (or as a consequence 1): Examiner collarse Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as e consequence of): Examiner sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medical the as use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 1 🗌 Yes 2 No 1☐ Yes 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P 3 NO 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending ithin 24 hours after death.

o the Funeral Director: Af M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 151639

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ET 32. Registar's Signature

MOFF

31. Date filed (Month, Day, Year)

39640

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ysician Medical	1.	Decedent's Name (First, Mic George	Robe	rt	Freeman	III			2. Date of Dea Month Novemb	er 22,	2007	3. Time of Death
aminer	4a.	Facility Name (If not institute 25063 Delmar			er)			r Location of Death .a Springs	5		nty of Death)
eral ctor	2	Social Security Number 218–16–6464	6. Sex	M 2□F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7/20/]			elace (State or Foreign etry) sylvania
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If be not	100	e. Street and Number 25063 Delmar					10f. Zip Code 2183			10g. Citizen USA	of What Coun	ntry?
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even Be	17.	. Father's Name (First, Midd		T				18. Mother's Name	,		name)	
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any injury or othe <u>once</u> .		a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 14 ☐ Donation 5 ☐ Other		emoval from St	ate Marc	etery, cren	sition (Name of natory or other place lemorial	ce)	28/07		on City or To	cings, MD
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Cay, Year) NOV 2 7 2007

32. Agistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Physician Year Joan Gilleland November 27, 2007 1314 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 K F Months Director 78 292-22-2010 January24,1929 Ohio the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2X No Director Silver Spring <u>Montgomery</u> Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ö #4 Brom Court 20906 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White Completed by 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) the Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Sadie Irvina Miller Elmer Gilland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) f Health a 27West Jefferson Street, Rockville, Maryland Marylin Pierre/ Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 Surial 2 □ Cremation 3 □ Removal from State 12-6-07 Lima, Ohio 4 Donation 5 Other (Specify) MemorialParkMausoleum 22. Name and Address of Facility
Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael Marzullo Fu
6009 Harford Road, Baltin
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6009 Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSI /Medical Due to (or as a consequence of) Examiner 54 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine /sician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the phys as IF FEMALE: nse yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Dav 5 Other (specify) P.O. | ed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. COROMARY SUNDROME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has perform DEMENTIA or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) M.D D0065024 person who completed cause of death (Item 23a) (Type, Print) MONIQUE GOM A 18101 Prince Philip Dr OTney

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 1 1 2007

Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

within 24 hours after deart To the Funeral Director completely filled in by the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL FRASIER MD 7503 Surratts RD Clinton, MD 20735 31. Date filed (Month, Day, Year) State NOV 2 6 2007 Registrar DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0065111

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

November

Month

2<u>3</u>

1944

2007

Anne Arundel

United States

Specify:

Real Estate

23d. Date of delivery

29d. Date signed (Month, Day, Year)

November 26, 2007

Month

14. Race - American Indian. Black, White, etc.

White

AR

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

9:31 AM

Division or Vital death. Director: after within 24 hours a To the Funeral I

Physician

/Medical

Marv

Ann

Guida

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konstantin A. Khludenev, M.D., 15825 Shady Grove Road, #140, Rockville, MD 20850 egistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59013

29b. Signature and title of certified

4 Homicide

29a. Certifier

determined

bludener, MA

_			1 - For State Registrar	State of Maryla	nd / Depa	artment of rtificate o	Health a f Death		Reg.	- Lune V V I	39644
	Physici	an	1. Decedent's Name (First, Middle, La	·				Mor		Day Year	3. Time of Death
	/Medic		Helen Sylvia						ember	23, 2007	1:15P M
	Examir	er	4a. Facility Name (If not institution, gire				i, or Location o	f Death		4c. County of Dea	
			9 Jenkins Creek 5. Social Security Number 6.		s. last birthday)	Cambr:		24 Hrs. 8. Date	of Birth	Dorches	
	Funeral Director		213-22-9942	1□ M 2□X 79		Months Day		Min. (Moi	of Birth oth, Day, Ye	1928 Mar	thplace (State or Foreign ountry) Cyland
	ס		Usual Residence of Decedent			<u> </u>					
5	Maryland -f ehow lled at	_	10a. State 10b. County		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
U'	Ba-f	Director	Maryland Dorches	ter	Camb	ridge					
3	with th		10e. Street and Number	- 1		10f. Zip Code			10g.	Citizen of What Co	ountry?
3	eath is 23,	Funeral	9 Jenkins Creek R	12. Was Decedent Ever in	115 13		513	nin? /Specify Ye	s or No-	USA 14. Race - Ame	erican Indian
- 40	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No				gin? (Specify Ye , Puerto Rican, e	etc.)	Black, Whit	
036	urs a	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2XIN	lo Specify:			Specify:	Vhite
9	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occ	cupation	of working	166	. Kind of Business	/Industry
7	the second	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use ret	ired)		D -	4 41 T. 1	
2	lygiar her th		11	41	Bookk	eeper	10 Matha	r's Name (First,			ber Store
and	ntal H	Be	17. Father's Name (First, Middle, Las								
ž	hould d Mei mark matic	၉	Charles Louis Pos 19a. Informant's Name/Relationship	-	19h Maili	na Address (Stre				lecheck	Zin Code)
Maryland 21215-0036	d2s than trau		Sylvia Cheesman/D							dge, MD	
	Heal Heal tem	2 8	20a. Method of Disposition			osition (Name of matory or other p		Date	_	. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mackial Examiner must be notified at once.	- 3	1 X Burial 2 ☐ Cremation 3 (4 ☐ Donation / 5 ☐ Other (Speci	nemoval from State				.1/28/20	07 Se	ecretary,	MD
噐	mit. I	1 1	21. Signature of Funeral Service Line		2	2. Name and Ad	dress of Facilit	y			
m	Depa Impo	2.9	Thomas I	J. Juli		eller Fu 06 Main	neral I Street	Home, P. , East N	O. B Iew Ma	ox 207 rket, MD	21631
			23a Party. Enter the disease, or conshock, or heart failure. List only	nplications that caused the de							Approximate Interval Between
	Physician	6 7	Immediate Cause (Final disease or condition	Gast	mc Co	ncer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons							
1	Lxammer	_	Sequentially list conditions,	b. Due to (or as a cons	equence of):						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events	545 15 (5, 45 4 55)	04401100 017.						
Ć	be execul icien and burial-trar	Exa	resulting in death) Last	Due to (or as a cons	equence of):	·					
760,	ysicie	cai		d							
68	tifica ng ph as th	Medi	15.55.111.5								
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregna	ncv			23d. Date of de	
	e dea the at	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ØNo	4 Pregnant at time of 9 Unknown		Other (specify)				Month	Day Year
P.O.	d by teletach	P.	9 Unknown Part II. Other significant conditions	contributing to death but not s	ogulting in the u	andorhijan on ion	arrea in Bost I	22	a Did tobac	on use contribute t	o the cause of death?
g,	The law requires that the death certificate be executed to has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	ğ	Takin olior significant contractions	contributing to death but not i	936King #1 (18 G	indenying cause	giveri ii i aici.	23	1 ☐ Yes		robably 4∑Unknown
Ö	v requ	ete						24	a. Was an	_	utopsy findings available
ě	62 CA	Completed							autopsy performed	prior to death?	completion of cause of
-	<u>⊢</u> ÷ 8	Ö	25. Was case referred to medical				OR Place	of Death Chec	Yes 2⊠	No 1 □ Yes	2 □ No
tal	:		examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Dther			e 6 □Other (Spe	ecify)
Vital F	/siclan: The law s certificate has b director, page 2 s	0 8	1 ☐ Yes 2 ☒ No			of 28c. Ir	njury at Vork?			njury occurred	
of Vital F	g Physiclan: ler this certifica neral director, p	To B	27. Manner of Death	28a. Date of Injury	Injury						
ion of Vital F	anding Physiclan: lath. pr: After this certifica	To B	27. Manner of Death 1 [X]Natural 5 □ Pending investigation		Injury		☐Yes 2☐I	No			
ivision of Vital F	r Attending Physiclan: for death. irector: Affer this certifica i by the funeral director. I	To B	27. Manner of Death 1 ☒Natural 5 ☐ Pending	be One Blace of laws As	home, farm, st	M 1	☐Yes 2☐I	28f. Loc	ation (Stree or Town, S	t and Number or Ritate)	ural Route Number,
Division of Vital Records,	utal or Attending Physiclan: urs after death. urst Director: After this certifica illed in by the funeral director. I	Certification: To B	27. Manner of Death 1 (\$\frac{1}{2}\) Natural 2 \(\triangle \) Accident 3 \(\triangle \) Suicide 4 \(\triangle \) Homicide 5 \(\triangle \) Pending investigation of determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	M 1	□Yes 2□I	28f. Loc City	or Town, S	itate)	
Division of Vital F	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification and filled in by the funeral director.	Certification: To B	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 27 Medical Exa	28e. Place of Injury - At building, etc. (Spe	thome, farm, stricify)	M 1 reet, factory, offine th occurred at the	Yes 2 1	28f. Loc City	or Town, S	e(s) and manner a	s stated.
Division of Vital F	o the Hospital or Attending Physician: within 24 hours after death. o the Funeral Director: After this certifical ompletaly filled in by the funeral director.	To B	27. Manner of Death 1 (\$\frac{1}{2}\] Accident 3 \sqrt{2}\] Suicide 4 \sqrt{2}\] Homicide 29a. Certifier 1 (\$\frac{1}{2}\] Certifying P	28e. Place of Injury - At building, etc. (Spe	thome, farm, stricify)	M 1 reet, factory, offi th occurred at the ovestigation, in m	Yes 2 1	28f. Loc City	or Town, S to the caus e time, date	e(s) and manner a	s stated. e to the cause(s)
Division of Vital F	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	Certification: To B	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigatic determined	28e. Place of Injury - At building, etc. (Spe	thome, farm, stricify)	M 1 reet, factory, offi th occurred at the ovestigation, in m	Yes 2 I	28f. Loc City	or Town, S to the caus e time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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Division of Vital F	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completaly filled in by the funeral director.	Medical Certification; To B	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who David C. Halvers 31. Date filed (Month, Day, Year)	28e. Place of Injury - At building, etc. (Spe thysician: To the best of my k printer: On the basis of examinand manner stated.	chome, farm, strictly) cnowledge, deat nation and/or in the control of the contr	M 1 reet, factory, office the occurred at the investigation, in m 29c. Lice Print) Drive, S	e time, date an ly opinion, dea	28f. Loc City of place, and due th occurred at the	to the caus e time, date	e(s) and manner a and place, and du Date signed (Mon	s stated. e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** WILLIAM L. GREEN 1150 a M 19 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NUISING Home Harfora De. Havie brace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 XM 2 ☐ F 215-12-9419 Director 87 JUNE 25. 1920 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh notified 1X Yes 2 □ No Director MARYLAND CECIL PORT DEPOSIT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene, ant: If Item 27 is marked other than "natural", or Items 23a or? ral", or Items 23a or Examiner must be r 306 ROWLAND DRIVE 21904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by BLACK 3 Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PURCHASING AGENT FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked STURGIS BROOKS MARGARET MARTE GREENE Item 27 is marke other traumatic ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN GREEN / DAUGHTER 306 ROWLAND DRIVE, PORT DEPOSIT, MARYLAND 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO., INC 11/21/07 WEST CEHSTER, PA 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE 21. Signature of Funeral Service Licenses MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 17H6046 **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached the 9☐ Unknown Ö 9 I Inknown þ 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has perform certificate Vital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA ō this s after death.

I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide vithin 24 hours are:

To the Funeral Dir To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

Green

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

200 6

30. Name and addy

31. Date filed (Monti

29c. License number

29d. Date signed (Month, Day, Year)

Reg	. No.?	n	07	3	Q	6	4	-
f Death	-	U	0 1	3. T	ime	of E	Deatl	n
	Dav		Year				0	

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.

ゴも川にE GRANVILLE Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar Certificate of Death Reg. No.2 0 7 3 9 6 4 6										46					
Physicia /Medic		1. Decedent's Nam Janice		e, Last) ranville						2. Date of E Month	Da	5,20	ear	3. Time of D	P M	
Examin	er	CIVISTA	MED	n, give street and nu	TER			LA	PLA	TA			CHA	4RL		
uneral irector		5. Social Security N 209-18-7	762	6. Sex 1 □ M 2 🕱 F	7. Age (In yrs. I		Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E 9 (Mpn/h)	Birth 92 7 ear)	9	9. Birthp Cour	place (State or I	Foreign
>		Usual Residence of 10a. State			100 City	, Town or L	costico								tod lasids Oits	h 1 14
a-f shov tifled at	Director	MD	10b. County Char	rles		aldor:									10d. Inside City 1 ☐ Yes 2	
or 28 e no)ire	10e. Street and Nu	mber				10f. Z	ip Code				10g. Cit	tizen of Wh	at Cour	ntry?	
23a o		1206 Mars	shall 1	Lane				206	502				USA	1		
tems er mu	Funeral	11. Marital Status		Armed F		S. 13.	Was Dece	edent of H ecify Cuba	lispanic Ori an, Mexica	igin? (Sp n, Puerto	ecify Yes or t Rican, etc.)	No-	14. Race - Black,	Americ White,		
ıral", or i I Examir	þ	1 □ Never Marr 3 🙀 Widowed	_	If Yes. G	2 ∏ No ive ∂ates:		1 ☐ Yes		Specify:				Specify:		ite	
'natı dica	ete	(Spec	15. Deceder cify only highe	nt's Education est grade completed)		(Giv	edent's Us e kind of w	ork done	during mos	t of work	ing	16b. K	(ind of Busi	ness/in	dustry	
than the Me	Completed	Elementary/Seco	ondary (0-12)	College	1-4or 5+)		DO NOT		d) -			Fe	dera1	leral Government		ıf
other ent, i	Be C	17. Father's Name	(First, Middle,	Last)					18. Mothe	er's Name	e (First, Midd				Vermen	
arked atic ev	To B	Murvingto	on Ort				Viola Cesario Ort									
27 is me er trauma		19a. Informant's N					ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall Lane Waldorf, Md. 20602									
Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis 1 ☐ Burial 23 4 ☐ Donation	remation	3 □Removal from	State	lace of Disp emetery, cre nsfie	ematoryi or	other plac			Date /27/07		ocation - C	•	·	
Importa any Inju		21. Signature of Fu	Approximate shock, or heart failure. List only one cause on each line.													
sician		Immediate Cause	(Final	r complications that t only one cause on	caused the death	n. Do not er	nter the mo	ode of dyir	ng, such as	cardiac	or respiratory	arrest,		i	Approximate Interval Betwee Onset and De	een eath
ledical aminer		disease or condition resulting in death) Due to (or as a consequence of): PFRITONIAL DIAUSIS														
nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	b. Due to	(or as a consequence of the cons	,	2 = 1	L A1	121	AI	luei				ÝR	
sician and burial-tra		that initiated events	Cause (Disease or injury that initiated events resulting in death) Last c						quence of):							
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To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? □ No	1 ☐ Live	nant at time of d	I death 3	□Ectopic □ Other (s		у			23d. Date of delivery Month Day Year			ear	
deta		Part II. Other signi	ficant condit	ions contributing to	death but not resi	ulting in the	underlying	cause giv	en in Part	l.	23e. Di	d tobacco	use contrib	ute to t	the cause of de	ath?
en sigr	ed by										1[Yes 2	2 □ No 3	B ☐ Pro	bably 450Ur	nknown
ate has beo page 2 sho	Completed							·			24a. Wa au pe 1 Yes	topsy rformed?	pri de	or to coath?	opsy findings avompletion of cau	vailable use of
rtific ctor,	Be (25. Was case refe	rred to medica	al					26. Płace	e of Deat	th (Check onl					
nis ce direc	To E	examiner? 1 ☐ Yes 2 ☐	No	Hospital:	Anpatient 2	ER/Outpatie	ent 3 🗆 E	Oth	ier: 4□ Ni	ursing Ho	ome 5□Re	esidence	6 □Other	(Speci	ify)	
: After the funeral	tion:	27. Manner of Deal 1 Natural 2 Accident	5 ☐ Pendi	28a. Date (Mo. igation	e of Injury nth, Day Year)	28b. Time Injury	of M	28c. Injui Wor 1 🗆	yat rk? Yes 2 □	No	28d. Describ	e how inju	ury occurred	d		
I Director	Certification:	3☐ Suicide 4☐ Homicide	6 Could deterr	nined Zoe. Plac	e of injury - At ho ding, etc. (Specif	ome, farm, s	treet, facto	ory, office				ı (Street a Town, Stat		or Run	ral Route Numb	ier,
he Funera	Medical (29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Medica	ng Physician; To th I Examiner: On the and ma	e best of my kno basis of examina nner stated.	wledge, dea tion and/or	ath occurre investigation	ed at the ti	me, date a opinion, de	nd place, ath occu	, and due to the time	ne cause(s ne, date ar	s) and man nd place, ar	ner as s	stated. to the cause(s)	
To the	M	29b. Signature and	29b. Signature and title of certifier					29c. License number 29d. Date signed (Month, Day, Y					-			
		> / Saw					D-44436 NOV 26 200						200	1		
5		30. Name and add ASHVIN J.	0	who completed cau	~			RT	SUITE	102	WAIX	ont.	MD.	20	602	
Sta		31. Date filed (Mor		32.	Registrar's Signa	iture	_		-111	,	, - 4100					
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DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001 NOV 28

2007

Jivision or Vital Records, P.O. Box 68760,

			1 - For State Registrar		f Marylar	nd / Depa <i>Cer</i>	rtment of H	ealth and Death		Reg. No.	007	39648
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Las</i> Eugene	•	glas		Harris		2. Date of Dea Month November		.007 Year	3. Time of Death 2:30 P M
	Examir		4a. Facility Name (If not institution, give 2318 Jameson Street	street and num	nber)		4b. City, Town, or Temple		ath		ounty of Death ince Georg	e's
	Funeral Director		Social Security Number 6. S	ex KEKM 2□F	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mil		h	9. Birthp	place (State or Foreign stry) ington, DC
	72 hours after death with the Maryland Instural; or Items 23a or 28a-1 show dical Examinat be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo 10e. Street and Number	rge's		y, Town or Lo				10g. Citize	1 an of What Cour	0d. Inside City Limits 1 ☐ Yes ※ No
٥	after death with or Items 23a o officer must be	Funerai	2318 Jameson Street 11. Marital Status 1 □ Never Married 2 ፟ Married	12. Was Dece Armed For 1 Tes If Yes, Give	ces? 217 No	li li	Vas Decedent of Hi Yes, specify Cuba		(Specify Yes or No erto Rican, etc.)	- 14	USA Race - Americ Black, White,	etc.
9500-6171	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Proporters of Health and Mental Hygiene. Proporters of Health and Hygiene. Proporter of Health and Hygiene. Proporter of Health Hygiene.	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	Year or Da	ites:	16a. Deced (Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired,	uring most of w	vorking	16b. Kind	of Business/Inc	ite
yiang 21	ild be filed v lental Hygie ked other t ic event, III	To Be Co	10 17. Father's Name (First, Middle, Last) Charles Wats	on Ha:	rris	FTE	ctrical Eng		ame (First, Middle,		evators umame)	
Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (•		1			Rural Route Numbe			Code)
Hore,	Pages 1 arent of Healert if item		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation _5 □ Other (Specification of the content of the conten	Removal from S	State	Place of Dispos cemetery, cren	sition (Name of natory or other place) L Cemetery	9)	Date 29/2007	20c. Loca	ation - City or To	
Pailino	permit. Departm importa eny inju		21. Signatur Funeral Service Licen		1	22	. Name and Addres		George P. Oxon Hill,	Kalas	Funeral I	Home PA
	Physician /Medical Examiner		23a. Pan 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	aDue to (d	ONGEST:	IVE HEA	RT FAILUI	RE	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death MONTHS
,007	ficate be executed physicien and is the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	ORONAR) or as a consequence or a consequence or a cons	uence of):	Y DISEAS	<u> </u>				years
O. DOX 00	To the hospital of Attending Physician: The law requires that the death certifical within 24 hours after death. After this certificate has been signed by the attending placements Director: After this certificate has been signed by the attending placempletely filled in by the funeral director, page 2 should be detached for use esting the properties of the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ∏ Feta antat time of d	ildeath 3□	Ectopic pregnancy Other (specify)			230	d. Date of delive	ory Day Year
Cords, T	equires that an signed by ould be deta	by	Part II. Other significant conditions of Chroni				derlying cause give ary Disea			obacco use		ne cause of death?
מו שבי	n: The taw re licete has be r, page 2 sho	Completed							1 ☐ Yes	sy rmed? 211 No		psy findings available impletion of cause of
5 :	nysicia nis certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatient	3 DOA Othe	_	eath <i>Check</i> o <i>nly</i> o		☐Other (Specify	v)
	auth. or: After ti he funera		27. Manner of Death 1 Natural 2 Accident 5 Pending investigation		f Injury n, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 ∐No	28d. Describe h	iow injury o	occurred	
	urs after dersi Direct	Certification:	3 Suicide 6 Could not be determined	buildin	g, etc. (Specif	y)	eet, factory, office		City or Tow	m, State)		l Route Number,
:	n 24 hou n 24 hou ne Fune pletely fi	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the lainer: On the ba and mann	sis of examina	wledge, death ition and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occ	ce, and due to the courred at the time, o	ause(s) ar date and pl	nd manner as st lace, and due to	ated. the cause(s)
1	Within Comp	Me	29b. Signature and title of contifier				29c. License	number 9431			signed (Month, l ber 26,	
1	21		30. Name and address of person who of Frank M. Ryan	MD 1170	01 Livi	ngston		03 Ft.	Washingto	on, Ma	aryland	20744
	Sta Registr		31. Date filed (Month, Pay, Year) NOV 2 7 200		ogistrar's Signa	iture	d.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 23, 2007 4c. County of Death Wilbur Hall Nov 3.00 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laure1 Prince George Cherry Lane Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1₩ M 2□ F Yrs. 10/10/1931 **Director** 216-32-7847 Clarksburg, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ns 23a or 28a-f show must be notified at 1 ¥Yes 2 □ No Funeral Director Prince George Laurel MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9001 Cherry Lane USA 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give ★ Year or Dates: Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PG County Schools Custodian 6 7 is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental William Hall Isabel Hall P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health and Important: If item 27 is me any injury or other* 19a. Informant's Name/Relationship (Type. Print) Goldie Smith (Sister) 5815 Cherrywood Lane Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 11/26/2007 Riverdale, Maryland 22. Name and Address of Facility Cedar Hill Funeral Home 21. Signature of Funeral Service Licensee Mary E. Hedgman M01374 4111 Pennsylvania Ave. Suitland, Maryland 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Arteriosclerosis Carliovascular Disease
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician at the burial Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) Ö the 9□Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Senile Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 perform certificate ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA ပို 1 Inpatient After this of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation thin 24 hours after ucco...

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 Nov. 26, 2007

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED SADIQ, MD 14333 Laurel Bowie Road Suite 208

NOV 2 7 2007

D24721

Laurel, Maryland 20708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ Rosa Lee Hamlin 2352 hrs Medical Examiner November 11, 2007 Rosa L. Hammond 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Clinton Prince George's Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Months Director 01/28/1954 Country) Md. 53 212-64-6836 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits any 10a State 10b. County 10c. City. Town or Location s 23a or 28a-f show e notified at once. D. C. Washington 1 Y Yes 2 No 28a-f show hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1113 19th Street, N. E. 20002 U. S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No ē Black Yes 2 X No specify: 4 X Divorced Specify: Widowed Yes. Give Year ≥ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical more, MD 21215-0036 Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene. 12th School Aide DC Public Schools 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlie Harris Hazel Tate marked event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt; If item 27 is m (Daughter) 1113 ±9th Street, N.E. #5 Elena M. Harris Washington ,DC 20002 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important; I 11/24/2007 Chesapeake Crematory Beltsville, Md. 4 Donation 5 Other Specify: 3447 14th Street, N.W. 22 Name and Address of Facility 21. Signature of Funeral Service License W. H. Bacon Funeral Home, Inc. Washington Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease ≂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED #1.PerME.g875, 1/24/08 TI the attending physician ed for use as the burial X Box 68760, IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Records, P.O. contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed' Yes 2 certificate 1 🗸 Yes No or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) of Vital Be examiner? Hospital: Nursing Home 5 Residence 6 Innatient 2 V ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Nov 11, 2007 Pedestrian struck by auto 1759 hrs Division 1 Natural Pending 1 Yes 2 V No death. Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) N/B Rte 5 @ Woodyard Rd, Clinton, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 12, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day Year) NOV 2 6 200

			101	epartment of Health and N Certificate of Death		iene 0 0 7	39651
ī	Dhysisi	200	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Yeer	3. Time of Death
	Physici /Medic		LILLIE HARIUS		11	19 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deal	_
	Francis		Cherry Lane Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Laurel av) If Under 1 Year tf Under 24 Hrs.	8. Date of Birth		George's thplace (State or Foreign
	Funeral Director		578-26-7590 1□M 2 F 86 Yrs	Months Days Hours Min.	(Month, Day, Sept 5,	Year) Co	th Carolina
	pu 🛊 😅		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	el acation			10d. Inside City Limits
	Aaryla f sho	ō					1 ∰Yes 2 □ No
	28a-	Director	Maryland Prince George's Hyattsv	rille 10f. Zip Code	10	Og. Citizen of What Co	ountry?
	h with	al DI	7333 New Hampshire Ave.	20783	I	United Sta	tes
	ems 2	Funeral		13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14 Bace - Ame	ancan Indian
36	s after , or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Coocity	African
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show avent, If a Medical Evarial or russ be notified at	ed p	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. De	ecedent's Usual Occupation	.	16b. Kind of Business	American
212	hin 72 an "na	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ing		
	ed wit	Con	12 years Emp1	oyee for Bureau of			rnment
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e <i>(Fir</i> st, <i>Middl</i> e, A Minniewe	,	
2	hould d Mer marke matic	1 0	James Mays 19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rur			Zin Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, it a Medical Evarut act must be notified at once.		1 1 11 1	35 Albert Drive Mit			
č.	s 1 a of Hea item othe		nomotone	sposition (Name of crematory or other place)	Date 2	20c. Location - City or	Town, State
<u>E</u>	Page ment c ant: If ury or		I NIBURAL 2 I Cremation 3 I Hemoval from State	ncoln Cemt. Nov.	23, 2007		
Baltimore,	Departit. Departit Importit any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility St. 4001 Benning Road,			
	20 5 s a		John , Llucy The				Approximate
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	:St,	Interval Between Onset and Death
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	Examiner		PAOK	INSON'S A	CENC	1	
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		31.34.		
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<u>О</u> .	nat the d by ti letach	Phy	a Douglows		22a Didah		the name of death?
Š,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		Part It. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		accouse contribute to s 2 ∰X10 3 □ Pr	othe cause of death?
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<u>_</u>	nyaici nis cer I direc	To B	examiner? 1 Yes 2 No	Other		nce 6 Other (Spe	cify)
Division of	Attending Physician: r death. ector: After this certifici by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Tim. Injur	ry Work?	28d. Describe ho	w injury occurred	
8	death death stor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location (Str	eet and Number or Ri	im I Pouto Number
<u>></u>	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	Street, ractory, office	City or Town		arar noute reamber,
	spita hours ineral y fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	(Check only 2 Medical Examiner: On the basis of examination and/o and manner stated.				
		Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
	2		- Wylly "	0004521	7	11/201	.07
	90		30. Name and address of periodn who completed cause of death (Item 23a) (Tyl	6201 Greenber	#415	Colle	SEPK MO
	Sta	te	31. Date filed (Mogth, Day, Year) NOV 2 6 2007 NOV 2 6 2007	6 -VI YKECHDELF	Y CA		20740
	Registr	-	NOV 2 6 2007 Garen D. Speck				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:45 A. ^M Warren Asbury Hancock 19,2007 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Thomas More Nursing & Rehab. Ctr. Hyattsville Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**X** M 2 □ F 86 1/14/21 Saxton, Pa Director 579-18-1641 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Washington 1 ☐ Yes 2 ☐ No D.C. Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 U.S.A. 4804 Sheriff Rd., N.E. 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Mail Handler 10th 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Edith R. Andrews Robert A. Hancock ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2131 Vittoria Court, Bowie, Maryland 20721 Juanita J. Grillo/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/07 Washington, D.C. Mt. Olivet Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lars **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical After this certificate has been signed by the attendin funeral director, page 2 should be detached for use a 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 2 □ No 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 4 hours after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 흔 01852 Successing Rd Hyatto: 1/elle 20181 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1/22/2007 **Physician** Charles Bixler Hobgood 4:00ath /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 □ F 92 Yrs 5/6/1915 NC Director 237-07-0026 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annea. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2☐No Director MD Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 2319 Westport Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo White Specify: Completed by 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Plant Manager Capitol Milk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hobgood Annie Dare Hornaday Charles Bixler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Benjamin 2319 Westport Lane Crofton, MD 21114 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 11/27/07 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1 Gatal 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician /Medical Due to (or as a consequence of): **Examiner** Adrtic Sequentially list conditions, if any, leading to firme datacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t Division or Vital Records, P.O. Box 68760, as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by difficult colites 1 Tes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate ha 1 Yes 2 ₽40 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/22/2007 EL B, MD 2001 Medical Parkung Annapolis, NO 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reynaldo Lee-Llace-II, MD 31. Date filed (Month, Day, Year) NOV 2 6 2007 Registrar

		1	For AMEND#23A PER State Registrar AACO HEALIII		11/29/07	Cer	tificate of l	ealth and N Death		Reg. No2	107	39654
	vsician		. Decedent's Name (First, Middle ADRIAN	le, Last)	TON				2. Date of De Month	ath 2 Day	O ^{Year}	3. Time of Death 17: 57 M
	ledical aminer		a. Facility Name (If not institution		LAND		BALTI	MORE			ty of Death	
Fune Direc		5	. Social Security Number 220–17–4328	6. Sex 1	7. Age (In yrs. I 28	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 03/02)	th ly, Year) 1979	Cou	place (State or Foreign ntry) bama
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the Ma	Director		MD Anne A	Arundel	Han	over	10f. Zip Code			10g. Citizen o	f What Cou	intry?
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aryiand Z1Z13-UU30 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show	xaminer must	Dy Furier	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ※ Divorced	rried Armed Fo	2∭ No ve		Was Decedent of H f Yes, specity Cuba I ☐ Yes 2【】No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecity Yes or No Bican, etc.)	Spec		
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Iryiand 2 should be filed nd Mental Hyg marked other	atic even	ă	Donald	Robert		Н	inton	Cho	ng		Min	
Mary d 2 shouth and N	trauma		19a. Informant's Name/Relations	ship <i>(Type. Print)</i> Moth	NO.16		g Address (Street Gesna D:				vn, State, Zi	ip Code)
Saltimore, M sermit. Pages 1 and 2 Department of Health mportant: If Item 27	any injury or other traumatic		Chong Hinton 20a. Method of Disposition 1 □ Burial 2X Cremation 4 □ Donation 5 □ Other (3 □Removal from	State 20b. F	cemetery, crer	sition (Name of matory or other pla		Date 28/07	20c. Locatio		
Baitim permit. Pag Department Important: I	any injur once.		21. Signature of funeral/Service			0.0) Name and Addre	on of English			-	Ave Ann, MD
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or Vital Records, P.O. Box 6 Physician: The law requires that the death certific this cartificate has been signed by the attending i	should be detached for use as the bur	To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkritions contributing to 6 Pregion of the property of	utcome pf pregnibirth 2 Fetsgrant at time of conown death but not research ancy al death 3E death 5E sulting in the u 28b. Time o Injury owledge, deal	Other (specify) _ nderlying cause given nt 3 DOA Other 28c. Inju Wo M 1 reet, factory, office	26. Place of Derher: 4 □ Nursing Hry at rk? Yes 2 □ No ime, date and plac opinion, death occ	24a. Wa aut put 1 Yes ath (Check only dome 5 Re 28d. Describe 28f. Location City or T	tobacco use c Yes 2No s an 24 s an 24 some 2 2 2 2 3 No cone) sidence 6 2 2 2 3 No cone) sidence 6 4 2 3 2 3 2 3 2 3 2 3 2 3 2 3 2 3 2 3 2	Month ontribute to o 3 Pro ib. Were au prior to c death? 1 Yes Other (Spec curred	the cause of death? obably 4 Unknown utopsy findings available completion of cause of 2 No cify) ural Route Number,	
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DHMH 17 Rev 1/2001

ORIGINAL

1- State Registrar #12 per fh, 12/04/07, eb Certificate of Death Amend item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** 1640 M 25 Valentin Ilin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Salisbur Wicomico If Under 1 Year | UUnder 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2□F 299-38-5440 62 01-15-1945 Belgium Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD Wicomico Parsonsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32344 Old Ocean City Road 21849 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 5 Yes 25 No
17 Yes, Give Vietnam
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if item 27 is marked other than "any injury or other traumatic event, the Magong. Elementary/Secondary (0-12) College (1-4or 5+) 12 Building Contractor none Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mychaylo Ilin Anna Ilin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parsonsburg 10, MD 21849 Gertrude Ilin/Wife 32344 Old Ocean City Road Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory 11/29/2007 Salisbury, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Sarving List nsee 22. Name and Address of Facility Hinman funeral Home M) 0295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hespiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Admocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. ed by the a 9 Unknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed b ge certificale 2 No Division or Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X** No P 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined \kappa Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006618 11/26/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) salisbury mo J. Ngaiza, 145 E. CAIDII EB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 Roberta Brooksie Powley Jones December /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cam brida If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02.24.1904 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 103 214.07.9789 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No "natural", or Items 23a or 28a-f shedical Examiner must be notified Wingate Dorchester Director Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21675 2424 Wingate-Bishops Head Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuu any Injury or other traumatic event, the Medical any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair & Cosmetology Beautician Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Powley <u>Archie Jones</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jacqueline J. Vickers/Daughter 203 Belvedere Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State DorchesterMemorialPark12.3.2007 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Jensture of Funeral Sen e Licensee Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner KENA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner bunial-tran and attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 ☐ Other (specify) ed by the a detached for signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s SEVERE DEMENITIA 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 npatient 2 ER/Outpatient 3 DOA ၉ in by the funeral 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death, I Director: After t Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident Accident 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

6 Could not be determined

1 1 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

063063

29d. Date signed (Month, Day, Year)

3 DURCHESTER GENERA 31. Date filed (Month, Day, Year)

Registrar's Signature

erson, who completed cause of death (Item 23a) (Type, Print) Stephen Olaes Rualo, M.D. ER GENERAL HOSPITAL, 300 Byrn St., Cambridge, MD

State Registrar

Medical

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Registrar

State

SPL-VADOR

31. Date filed (Month, Day, Year)
NOV 2 7 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 HDS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Flate Registrar Amend #20a Per FH T1/27/Qentificate of Death Reg. No. Reg. No. 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last, Day **Physician** 23,2007 5:00 Nov Richard Lee Jenkins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George 3601 Maywood Lane
5. Social Security Number 6. Sec Suitland If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 20 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral ™** M 2 . F .1942 577-56-5991 Dec. Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☑ Yes 2 ☐ No Director Suitland MD Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or Items 23a or Medical Examiner must be n USA 3601 Maywood Lane 20746 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) PG County Schools Mechanic traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil h and Mental H 7 is marked oth Be Ε. Lee Jenkins Lorena M. Alvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ament of Health a 6756 Jasmin St. ST. Leonard, MD 20685 Ricki L. Jenkins other 1 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 11/27/2007 | Riverdale, MD 22. Name and Address of Facility Cedar Hill Funeral Home enseeلر 21. Signature of Funeral Service 746 Approximate Interval Between Onset and Death Mary Hedgmon MO1374 Pennsylvania Ave. Suitland, MD 20746 4111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANTEA **Physician** /Medical Due to (or as a consequence of) Examiner cousing her conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, pe Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy perform 2□ No 2 No 1 ☐ Yes certificate Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this |
Completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🌿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** 23 ROBERT **JACOB** 2007 Nov. 11:30 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F Director Oct. 28, 1951 Washington, DC 56 578-66-3506 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2x No Director Prince Georges MD Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1306 Quid Ct. 20743 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th General Worker Washington Post permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joyce Nancy Comfort 2 Alex Jacob 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra T. Jacob/Wife 1306 Quid Ct. Capitol Heights, MD. 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 KI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk. Crematory 12-3-07 Riverdale, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Murray Funeral Home 4804 Georgia Ave.N.W. Washington, DC 20011 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardio /Medical Due to (or as a consequence of): **Examiner** ACULE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate has page 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Va + 559 7/00 MEHT MD 7
32. Registrar's Signature ARNAD 31. Date filed (Month, Day, Year) State NOV 2 7 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician Evelyn Marie Johnson** 9:20 A /Medical Nov 21, 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 240 Shore Acres Way Apt.#136 Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2□ Yrs. Director 213-46-8717 81 MD Oct 30, 1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location f show 10a. State 10b. County must be notified at 1 ☐ Yes 2 ☐ No Director MD Calvert Prince Frederick 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 240 Shore Acres Way Apt.# 136 20678 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked oth Be Ozella Height Andrew Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jean Gross/ Daughter-in-law 2031 Yew Court Saint Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any Injury or ot 1 DaBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11/28/07 Prince Frederick, MD Carroll Western Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home Bladys sevel 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has performed' 2 No or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation within 24 hours after community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054061 November 21, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD 20678 Road Suite 212 31. Date filed (Month, Day 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1- State Amend 23a, line b per phys. Registrar DOR, 12/6/07, LDB

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 3. Time of Death **Physician** 1124A M Hilton November 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner xskr General (ambridge HOSPITO 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 2□F Months Days Hours 218-34-8195 68 Jan. 6, 1939 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Dorchester the I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/6/3 U.5A Road 1006 Funeral JIMPSON 12. Was Decedent Ever in U.S. Armed Forces?

1 CPYes 2 No 1f Yes, Give Year or Dates: 10 5 7 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Black 3 ☐ Widowed 4 ☐ Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Company Apprentice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Aaron ဂ Jones Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

rnestine Jones Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/28/07 Veterans Cemetery Hurlock, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
HENRY Funeral Hone, R.A.

510 Washington St. Cambridge Maryland 21613

23a. Part I the the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Fine) 4 Donation 5 ☐ Other (Specify) Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** allure JOHER /Medical Due to (or as a consequence of Examiner Aspiratio hours Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Kestrickiu tears. use as the burial-tran P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1X Yes Renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Sar Cadusis certificate 2 🗌 No 1 ☐ Yes 1∐ Ýes 2XQNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 Yes 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After of the funeral price in by the funeral completely filled in the funeral completely filled in the funeral complete 1 Natural 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 □ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/22/07 65528

State Registrar 31. Date filed (Month NOV 2 7 2007

Labib MD

Ahmed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Restrar's Signature

Combridge MD 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 25 2007 46. County of Death layne hnson SR. NOVI /Medical 4b. City, Town, or Location of Death 4a. Facility Name (I) not institution, give street and (umber) **Examiner** Sherman Queen hester Way Annels If Under 1 Year 8. Date of Birth (Month, Day, Dec. 3) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 M 2 F Min. Months Days Hours 219-60-1611 Yrs. Dec. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1

Yes 2 □ No Puren Anne's nester the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21619 Sherman USA Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Self Employed 10 termar permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If item 27 is marked other i any injury or other traumatic event, tit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weeks ဂ္ James Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter St Baltimore, MD. 21223 Lexington Victoria Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chester, MD. 4 ☐ Donation 5 ☐ Other (Specify) hester Cometery 22. Name and Address of acility
HENRY FUNERAL 21. Signature of Funeral Service Licensee MD.21613 enre 510 washington 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 Months **Physician** 0 100 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 2 No 3 Probably 4 Unknown 1 □ Yes cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7007 30. Name and address of be son who completed cause of death (Item 23a) (Type, Print) CUP Rd Sale 300 MI) Besta Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 28 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Eleanore Bernice Klopping November 18, 2007 1301 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 6204 Blackburn Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Months Days Hours 1 □ M 2X F Yrs Ohio Director 274-14-7522 August30,1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show or 28a-f show notified at Y☐Yes 2☐No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or Items 23a or Examiner must be r 6204 Blackburn Lane 21212 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

Inst. If item 27 Is marked other than "natural", or Items 23, mir. If item 27 Is marked other than "natural", or other traumatic event, the Medicial Examiner must vny or other traumatic event, the Medicial Examiner must by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces Armed Forces:

Yes 2 No
If Yes, Give
Year or Dates: 42-45 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ▼No Specify White 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Juvenile Probation Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be John Krajewski Agnes Pelot မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10011 149th Street, E. Snohomish, Washington Mark Klopping 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/07 Toledo, Ohio 4 ☐ Donation 5 ☐ Other (Specify) <u>ToledoCremationService</u> 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac arres disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

ANNESLE

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

BALTIMORE

D0065094

11/18/07

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

ROAD 32. Registrar's Signature

Heather Jean Kinney State of Maryland / Department of Health and Mental Hygiene 2007 39664 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 29, Medical Examiner Heather 1245 hrs Jean Kinney 2007 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 123 Arch Street Cumberland Allegany 6. Sex 7. Age (in vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Social Security Number 214 98 0053 **Funeral** Foreign Maryland Country) Months Days Hours Director M 2 X F 26 Yrs 09/27/1981 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD Allegany Cumberland it: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once. death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 123 Arch Street 21502 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married Baltimore, MD 21215-0036
permit, Pages I and 2 should be filed within 72 hours after dea
Department of Health and Mental Hygiene. 2 X No Yes Widowed 4 X Divorced If Yes Give Year Yes 2X No specify: Specify. White ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Cassandra Kinney Unknown Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Arch Street, Cumberland, MD 21502 Carolyn Dolly / Grandmother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 12/03/2007 Cumberland Crematory Cumberland, MD Donation 5 Other Specify: 22. Name and Address of Facility dams family funeral Home, P.A. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 LEnter the disease, or co that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Cardi mesaly with biventricular dilatation Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical X AMENDED #5, perFh, PI line a-b, , 27, perME, g875, 1/11/08 TT X UNPENDED signed by the attending physician be detached for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 5 Prooably 4 ✔ Unknown Completed director, page 2 should 24a. Was an need 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✔ Yes 2 No 1 🗸 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital:₁ Other, FR/Outnatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 2 1 🗸 Yes funeral After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 within 24 hours after death. To the Funeral Director: Pending filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 30, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Kellogg **Physician** Hilda November 25, 12:00 P M 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 2004 Iverson Street Temple Hills If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 0 Ctober 31, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 203-03-9303 1 □ M 2 🖺 F 88 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ans: if Item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow ury or other traumatic event, the Medical Examinar must be notified at ury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Prince George's Temple Hills Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2004 Iverson Street 20748 TISA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒☒Io If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2XXMarried White Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weisenfeld Minnie Schwartzburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldon R. Kellogg / Husband 2004 Iverson Street Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 11/29/2007 Department of Important: If eny injury or once. Falls Church, Virginia King David Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. Funeral Service Licenses 4 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronar **Physician** /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year į in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4 Pregnant at time of death P.0. page 2 should be detached ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy 1 Tes 2XX No After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home SEX Residence 6 Other (Specify) Certification; To 1 Tes 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A 2 Accident the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗀 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ali Rahimian MD 7501 Surratts Road #205 Clinton, Maryland 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gran B. Speck Registrar

ORIGINAL

DHMH 17 Rev 1/200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician William Arthur Kuning Movember 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Memoria If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Illinois 87 May 20, 1920 Director 321-14-8331 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County and 2 should be filed within 72 hours after death with the Marylan ealth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Cambridge Dorchester Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21613 1744 Travers Wharf Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - Americen Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: white 2 WWII 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) government electronic technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Kuning Lillian Mischnick Injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health at
Important: If item 27 is n 9723 Polished Stone, Columbia, MD Brian Kuning son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/07 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee B-K.B 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACCIDENT Immediate Cause (Final CEREBRO VASCULAIZ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BOWEL ISCHEMIC SMALL Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Examine ATHEROSLEROTIC CARDIOVASCULAR The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, FIBRILLATION ATRIAL Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached i 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No 2DNO 1□ Yes 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: d in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: within 24 hours after To the Funeral Discompletely filled in

William A Kunina

State Registrar

D0059487

29d. Date signed (Month, Day, Year) 2007

30. Name an Address of person who completed cause of death (Item 23a) (Type, Print)

219 S. Washington St., Easton, MD 21601 John Botsis, M.D.

31. Date filed (Month, Day, Year) 32. Reg NOV 2 1 200

phulpotru

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 25, 2007 Se NOV eona /Medical harai 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Stelisbu Wiconico Peninsula Regional Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 217-90-0434 1 ☐ M 2 🛣 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director somerse CESS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) f Health and Mental Hygiene. Item 27 Is marked other than 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) cess Anne Md. 21853 Kersey-husband athan - Hamplen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Delmar 4 ☐ Donation 5 ☐ Other (Specify) Smith Funeral Service Linux Shu 23a. Part1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death ease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re-List only one cause on each line. Immediate Cause (Final ewas **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-trar Due to (or as a consequence of Box 68760, physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a Division or Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 has page 2 certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 🔲 Inpatient $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes မှ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death After 1 Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: ipletely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Û 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MD IAN 31. Date filed (Month, Day, Year) gistrar's Signature State NOV 27

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 030 aM **Physician** ovember Ronald R. Lee, Sr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 11X M 2 □ F Feb 28, Divide County ND 579-38-3660 1931 76 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1X Yes 2 □ No Director Prince George's Lanham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 9408 Eldred Place Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 XYes 2 No 1948− If Yes, Give Year or Dates: 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Printing Office marked other permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0. Gladys Burke Anton T.ee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10550 118th Ave., Largo, FL 33773 Michael A. Lee - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 11/28/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Jase 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCER Physician /Medical Due to (or as a consequence of): Examiner METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4x Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 FR/Outpatient Certification: To 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 1 HNatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

29b. Signature and title of certifier

(Check only one)

6510 KENIL WORTHAVE, SUITE 2400 RIVERDALE MD 20737 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

050 951

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Vovenesia 21, 2007 HOMER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALIS TENN If Under 1 Year If Under 24 Hrs. 8. C HOSPITHL CENTON BALTIMERE Nonth WEST Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min 96 24 South Carolina Director 1911 251-16-5589 Usual Residence of Decedent 10c. City. Town or Location r 28a-f show notified at 10a. State 10b County 10d. Inside City Limits Director ty∑Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r Funeral filed within 72 hours after death 6408 Walnut Street 21207

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: Black "natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publication Supervisor U.S. Coast Guard 10th. t. Pages 1 and 2 should be filed wrthment of Health and Mental Hygie trant: If item 27 is marked other theiry or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Latimer <u> Alice Williams</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 7824 Hanover Pkwy. #204 Greenbelt, MD. 20770 Alice R. Latimer/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Maryland National 11-27-07 Laurel, MD. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, d.C. 20011 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIONY GRATA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly 9 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. 1 □ Yes 2 □ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by HEART FAILURE: MITHAL REGURGETATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 NO CARC'NOMA 2 -No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ours after death.

Interest Director: After this of filled in by the funeral directors. Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of contifie 29c. License number 29d. Date signed (Month, Day, Year) November 21, 2007 Mes) 1950> 10: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nonthwest 169

DHMH 17 Rev 1/2001

State Registrar B. Canqua

ENLANDO

31. Date filed (Month, Day, Year)

nes

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 396 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 9:40 P Nov 20, Deborah A. LaFontaine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's 5613 Jamestown Road Hvattsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F 425-06-7389 52 Nov 28, 1954 Mississippi Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ns 23a or 28a-f shov must be notified at 1X☐Yes 2☐No Hyattsville Prince George's Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 USA 5613 Jamestown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 St Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Registered Nurse 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Niolet Edwin LaFontaine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7047 Kiln-Delise Rd, Pass Christian, MS 39571 Betty LaFontaine - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 11/28/2007 Pass Christian, MS Delisle Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final **Physician** letactation disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner nding physician and Ise as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Be Certification: To

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

or items 23a

'natural",

Health em 27 i

signed by the a this After s after decral Director: After npletely filled in by To the Hospital o within 24 hours aft To the Funeral Di

		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of De	eath (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5₺ Residence 6 Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 1 determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and pla aminer: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	

10 3

29b. Signature and title of cer-

A

29c. License number 29d. Date signed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

20007 3800 Reservoir Rd NW, Washington, DC

State Registrar

Medical

filed 2 6

State of Maryland / Department of Health and Mental Hygiene 17 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3-20PM 22 2007 MAE RUTH LEE NOV /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Co. General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X□XF 218-24-0690 MD Director 78 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 ie marked other then "naturel", or Items 23e or 28e-f show other traumatic event. The Modical Examiner must be notified at 1 ☐ Yes 2 ⊋ No MD Calvert Director Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12955 Barreda Blvd. 20657 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 11. Marital Status permit. Pagas 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Infrarement if item 27 ie marked other then "naturel" or Hemany injury or other traumain. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Grocery Store Elementary/Secondary (0-12) College (1-4or 5+) Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Ravmond Crawford Bever1y Mae Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3160 Shadow Park Lane Waldorf, MD 20603 Joyce A. Lee/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 【XRemoval from State `4 ☐ Donation 5 ☐ Other (Specify) Meto. Crematory 11/30/07 Alexandria. 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licents Glady 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician PROBABLE ACUTE disease or condition resulting in death) /Medical Examiner ATHEROSCLERO71C CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit cartificate be axecuted Due to (or as a consequence of): Box 68760. nding physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 010 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ ER/Outpatient 1 Tes 2 No 2 1 Inpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number NOV 27 2007 10023120 suite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rago Rd COUPT A 9650 Sant ShakUNIYAC

State Registrar

DHMH 17 Rev 1/2001

32. Registra Signature

2007

			1 - For State Registrar	State of M	Maryland /		artment of H		and Mo		iene g. No. 00	7	39673	3
	Physici	30	1. Decedent's Name (First, Middle	, Last)						2 Date of Deat Month	h Day	Year	3. Time of Death	h
	/Medic		Gardiner	Wood	Lus	sby				Novembe	r 26,20	007	8:05 a	М
	Examir	er	4a. Facility Name (If not institution,		er)		4b. City, Town, or		of Death		4c. County			
		₹ 3	Futurecare -		A /la /a-A	to the stands	Arno	old If Under :	24 Hrs	0.0-1	Anne			
	Funeral Director		5. Social Security Number 578–44–6722	6. Sex 7. / fX M 2 F	Age (In yrs. last	οιπησαγ) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,		Cou	' <u>'</u>	эıgn
20	* * * ·		Usual Residence of Decedent		83					June 7,	1924	Mar	yland	
	/land		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Lim	nits
	Mar	tor	MD Cal	vert	Su	ınder	land						1 ☐ Yes 2 💢	No
	h the	irec	10e. Street and Number			-	10f. Zip Code		-	1	0g. Citizen of W	√hat Cou	ntry?	
	72 hours atter death with the Maryland naturel', or Iteme 23e or 28e-f ahow disal Examinar must be notilled at	Funeral Director	920 Dalrympl	e Road			20)689			U.S	S.A.		
	eme erm	iner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. s?	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	gin? (Spe	cify Yes or No-		e - Ameri k, White,	can Indian,	
36	or It	y Fu	1 Never Married 2 Marri				1 ☐ Yes 21 No	Specify:	,	,		whi		
8	ure!	d by	3 Widowed 4 Divorced	Year or Date:										
21215-0036	"nat	Completed	15. Decedent (Specify only highes		16	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most	t of workin	ng	16b. Kind of Bu	siness/lr	dustry	
12	withi ene. than	ᇤ	Elementary/Secondary (0-12)	College (1-4d			itenance s		vi sor		tate na	arks	& planni	na
	Hygi Hygi other		17. Father's Name (First, Middle, L	ast)		пал	icenarice s			(First, Middle, M			a planii	119
<u>a</u> n	ld be lental ked o	To Be	Edward Henry	Lusby				N	Maude	Parr	rine I	ento	on	
Maryland	shou and M mer umet	-	19a. Informant's Name/Relationsh	tip (Type, Print)	1	9b. Maili	ng Address (Street a	and Numbe	r or Rural	Route Number	City or Town,	State, Zij	Code)	
	and 2 alth a		Helen L. Lusb	y, wife	9	20 E	alrymple	Rd.,	Sund	derland,	MD 20	0689		
ore	of He		20a. Method of Disposition	2 DBarrant from Sta	l como	of Dispo	sition (Name of matory or other place				20c. Location -	City or T	own, State	
Ĕ	Page nent ent: h		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		" Epip	ohan	y Cemeter	y 1	1-30	-2007 1	Forestv	ille	, MD	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ahow employing or other traumatic event, The Mardical Examinar must be notified at	-	Branchis of Funeral Service L	igens ulo	au .		2. Name and Addres		100	usch Fu ne, Owin		Home,		
	ā		23a. Part1. Enter the disease, or shock, or heart layure. List of	complications that caus	sed the death. D								Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Ad	mana	d	don	ner	1 +	de			Onset and Death URan	-
	/Medical		resulting in death)	Due to (or a	as a consequenc	ce of):	- OCA			01			of cars	
4	Examiner		Sequentially list conditions.	b								'		
	pe #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequenc	e of):								
	and I-tran	хаг	that initiated events resulting in death) Last	c. Due to (or a	as a consequent	e of):								
8760,	icate be executed physicien and s the burial-transit	alE	Due to (or as a consequence of):											
687	phys s the	Physician/Medical		d										
Box (that the death certitic ed by the attending p detached for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy						23d Dat	e ol deliv	erv	
ŏ	death a atte	clai	in the past 12 months?		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)				Mor		Day Year	
P.O.	t the c by the achec	hys	9 Unknown	9□ Unknown										
	The law requires that the death certitic tie has been signed by the attending p tage 2 should be detached for use as:	by P	Part II. Other significant condition	ns contributing to death	but not resulting	g in the u	nderlying cause give	en in Part I.		23e. Did tot	acco use contr	ribute to t	he cause of death?	_
ğ	equire en sig	edt	hyperter	7510M						1 □ Y€	s 2 No	3 Prol	bably 4 Unkno)wn
000	has be	Completed	Oser Tus	a dis	orde	1				24a. Was a	n 24b. V	Vere auto	opsy findings availa	abie
Ř	The ate ha	mo.	Ostonar	Thah	7					autops perform	ned?	leath?	2 No	OI .
ita	shrific ector,	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only on	· -			
×	hysid his co	ဥ	1 Yes 2 No	Hospital: 1 _ Inpa	itient 2 ERV	Outpatier	t 3 DOA Othe	r: 4 Nu	rsing Hom	ne 5 🗆 Reside	nce 6 Othe	er (Speci	fy)	
ū	Attending Physicien: or death. ector: Atter this certifica by the funeral director.	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year) 28t	. Time o Injury	Work			8d. Describe ho	w injury occurr	ed		
Sic	tend death stor: /	cat	2 Accident investig 3 Suicide 6 Could n	ot bo		,		Yes 2□N		DI 1 (O			18	
Division of Vital Records,	after after Direction by	Certification:	4 ☐ Homicide determi.	ned 288. Place of building,	etc. (Specify)	tarm, str	eet, factory, office		2	City or Towr		ar or Hur.	al Route Number,	
	spitel ours nerel tilled		29a. Certifier 1 Cartifying	Physician: To the be	st ol my knowled	lge deat	occurred at the tim	e date an	d nlace, a	nd due to the ca	ausa(s) and ma	0001 36 1	tated	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely tilled in by the tuneral director, page	edical	(Check only 2 Medical E	xeminer: On the basis and manner	of examination	and/or in	vestigation, in my op	pinion, deat	th occurre	d at the time, d	ate and place, a	and due t	o the cause(s)	
	To the Ho within 24 I To the Fu	Me	29b. Signature and title of certifier	A .			29c. License			1	9d. Date signed		*	
	/					M	DO	50	72	5	11-0	76-	2007	7
	5		30. Name and address of person v	who completed cause of	death (Item 23a	а) (Туре.	Print)	1/		11.11	,	11	2007 MD 211	
			Jenniterkie	dinger	8601	Ver	erars 1	Two	11	lille	rsvil	Le	MDZI	OB
**	Sta		31. Date filed (Month, Day, Year) NOV 2 8 2007	32. Regis	strar's Signature	M.		1	7					
F	Registr	ar	NO 1 6 9 2001	person 1	C. JUDB									

07-08924 Robin B. Ratliff

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

in B. Ratliff	State of Maryland / Department of Health and Mental Hygiene 2007 396							7	
	R	egistrar	2. Date o	Reg. No.		3. Time of Death	1		
Physicia dical Examir		Decedent's Name (First, Middle, Last) Robin B. Ratli	ii ii		Month Nove	mber 18, 20	Year 007	0442 hrs	
aji Exami		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location o	f Death		County of Death	lo.	1
*	П	553 Wilson Bridge Drive C2		Oxon Hill			ince George		-
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday)	If Under 1 Year If Under Months Days Hours	Min		D/YYYY) 9. Birti Foreigi	nplace (state of untrWashingtor	a.
Director	- 1	579-90-7691 1 M 2 XF 34	Yrs.	Months Days Hodis	Jar	3, 19	73 Col	intry) C.DC	-
		Usual Residence of Decedent	ty, Town or Locati	00				10d. Inside City Limits	1
v any		Tob. County	xon Hill					1 X Yes 2 No	
land f shov	5	Maryland Trines 3338		10f. Zip Code		10g. Citiz	en of What Cour	ntry?	1
Mary r 28a- ed at	Director	10e. Street and Number		20745		Un	ited St	ates	
th the 23a o		553 Wilson Bridge Drive #C2 11. Marital Status 12. Was Decedent Everin	U.S. 13. Wa	s Decedent of Hispanic Orig	gin? (Specify Ye			ican Indian, Black,	1
ath wi	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	lf Y	es, specify Cuban, Mexican	i, Puerto Rican, e		White, etc.	_1_	
ter de		3 Widowed 4 Divorced If Yes Give Year or Detect	1	Yes 2 X No specify:			Specify: Bla		4
ours at	d by	15. Decedent's Education (Specify only highest grade completed	16a. Deceder during m	nt's Usual Occupation (Give nost of working life. DO NOT	kind of work don Luse retired)	e 165. r	and or business/	moustry	
6 172 hc 1811 ft.	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	Tarr	yer's Assista	ant		Private		
within jene.	Completed	12 years 17. Father's Name (First, Middle, Last)	Law	18.Mothe	r's Name (First, N	Middle, Maiden	Surname)		7
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. anaked other than "natural", or items 23a or 28a-f show any event, the Medis A Examiner must be notified at once.	Be C	Clarence Ratliff			athleen				
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Titing 27 is marked other than "natural", or items 23a or 28a-f she mait. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medis J. Examinor must be notified at once	ToB	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Nu	mber or Rural Ro	ute Number, C	ity or Town, Stat	e, Zip Code)	Ì
MD d 2 sho lth and n 27 is		Colin Lewis - Husband		- 16th Ave.	Hyattsv	200.	Location - City o	r Town, State	\dashv
imore, MD 2 Pages 1 and 2 shoul nent of Health and N ant: If item 27 is n or other traumatic		202. Mountain 2 Compation 3 Removal from State	crematory or o					on, MD	
Pages ent of int: I		4 Donation 5 Other Specify:	Lee's Cr	ematory Name and Address of Facil	Dec. 1	t Fune			\dashv
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Funeral Service Licensee	22.	Name and Address of Facil 1001 Benning	Road. NE	. Washi	ngton, I	C 20019	-
		23a Part I. Enter the disease, or complications that caused tife de	eath. Do not enter	the mode of dying, such as	cardiac or respir	atory arrest, sh	ock, or heart	Approximate Interval	
Physician 'edica		failure. List only one cause on each line.						Death	
mine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequential content or condition resulting in death)	ce of):						
		Sequentially list conditions, b. Cardiomegaly a		ntricular hyperi	trophy				ㅓ
	ner	if any, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause	ce of):						4
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent property)	ce of):						
ecuted and and transit		d							\neg
D, be executed sician and	dical	X UNPENDED X AMENDED lien a-	b, PII,27,	perME, g875, 1/2	8/08 TT	12	3d. Date of deliv	/erv	\dashv
ox 68760 eath certificate I attending phys	N N	IF FEMALE: 23c. If yes, outcome of 23b. Was decedent pregnant in the		Fetal death 3 Ecto	opic pregnancy		Month	Day Year	
C 68	sician/M	past 12 months?		Other (Specify)					
Box e death c the atten			t	a underlying cause given in	Part I.	23e. Did tobaco	o use contribute	to the cause of death?	_
P.O. es that the igned by	2		not resulting in th	e underlying cause given in		1 Yes 2	No 3 F	Probably 4 🗹 Unknown	n
S, P.C uires that n signed l	7	Obesity				24a. Was an	24b. Were	e autopsy findings availal to completion of cause o	ble of
cords, law requir	1					autopsy performed Yes 2	? death	n?	
Zec The l	Completed			26 Place of De	ath (Check only o		NO I	165 2	_
Vital Rec	o Do Con	25. Was case referred to illedical	2 ER/Outpati	Other			idence 6 🗸 O	ther: Scene	
f V.	Ē F	27 Manner of Death 28a. Date of Injury	28b. Time		Vork? 28d.	Describe how	injury occurred		
on of nding Ph th. : After	e fumeral	1 X Natural 5 Pending (Month, Day, Year)		1 Yes 2					_
Division of Vital Records, tal or Attending Physician: The law requirers after death.	by the		- At home, farm, s	street, factory, office building		Location (Street		r Rural Route Number, C	City
ital or ratio	lled in	3 Suicide 6 Could not be determined (Specify)							
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.			owledge, death o	ccurred at the time, date an	d place, and due th occurred at the	to the cause(s) and manner as place, and due	stated. to the cause(s)	
To the within To the	omple	and mainter stated.	ation and/or inves	29c. License num		2	9d. Date signed	(Month, Day, Year)	_
	° :	29b. Signature and title of certifier		O.C.M.E.			November 18		
		Donna municinti, MID.	(N 02-)						
		30. Name and address of person who completed cause of deat Donna M. Vincenti, MD Assistant Medical	n (Item 23a) Examiner	111 Penn Street, Bal	Itimore, MD 2	1201			
	C		Signature						
Por	Sta ristr	e on ball mod mod 11 2007	, K.	marke !					

ORIGINAL

07-09221 Cora Morgan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ora morgan	1- For State Certificate of D	30	Reg. No. 2007 396
Physician ledical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Month	
	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	4c. County of Death
		Saithersburg If Under 1 Year If Under 24Hrs. 8. Date 6	Montgomery
Funeral Director		Months Days Hours Min	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign uary18,193% ohio
v any	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryland 28a-f show d at once.	Maryland Montgomery	Gaithersburg	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho	221 Booth Street	0f. Zip Code 20878	10g. Citizen of What Country? U.S.A.
5 - 1	1 Never Married 2 Married Armed Forces? If Yes, 1 Yes 2X No	ecedent of Hispanic Origin? (Specify Yes of specify Cuban, Mexican, Puerto Rican, etc. es $2\overline{X}$ No specify:	
hours at natural	1 Tor Dates:	Usual Occupation (Give kind of work done of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 Hygiene. other than " the Medical	Elementary/Secondary (0-12) College (1-4 or 5+)	er Assistant	School System
215-0036 be filed within 72 mial Hygiene. rked other than ent, the Medical	77. Father's Name (First, Middle, East)	18.Mother's Name (First, Mid	
2121; hould be fill and Mental It is marked tric event,	Frank Morgan 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	Zelma Le	
MD 2 shou alth and M 2 is n		Sandestine Houst	
re, re s l and f Healt lf item	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other	n (Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, MD 21215 pemit. Pages I and 2 should be file Department of Health and Mental Hy Important: If iten 27 is marked o injury or other traumatic event,	4 Donation 5 Other Specify: Bayview	Crematory 12-1-0	7 Baltimore, Marylar
Ball permit Depar Impor	0 1 1 0 9 11-	ne and Address of Facility Marzul	lo Funeral Chapel, P.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	9 Hartord Road B mode of dying, such as cardiac or respirator	altimore Maryland 212 ry arrest, shock, or heart proximate Interval Between Onset and
/Medical kaminer	Immediate Cause (Final disease a. Quetiapine intoxication		Death Death
	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): b.		
	J Sequentiany list conditions.		
٠, ١, ١	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		1
recuted and - transit	_ I		
60, ate be ex hysician te burial	XUNPENDED #ZDa, 27, 28a-f, perME, g874, IF FEMALE: 23c. If yes, outcome of pregnancy	12/13/07 TT	23d. Date of delivery
6876 ertificate ding phy		death 3 Ectopic pregnancy	Month Day Year
Box 687 ne death certific the attending ped for use as the	2 Fetal 23b. Was decedent pregnant in the past 12 months? 1	(Specify)	
P.O. E so that the d gned by the e detached	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
ords, P.C. w requires that as been signed to should be deta		1_	Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requints after death. In Director: After this certificate has been so an order of the funeral director, page 2 should the fifter of the page 2.			Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death?
The tiffcate or, page			Yes 2 No 1 Yes 2 No
of Vital Recoling Physician: The law After this certificate has funeral director, page 2 s		Other:	5 Residence 6 Other: Scene
ing Ph After t	27 Manner of Death 28a Date of Injury 28h Time of Injury		cribe how injury occurred
Sior Attend death. ector:	Natural 5 Pending Pending Investigation Fnd 11/28/2007 Fnd 9:30 p	AII I	ect ingested medication
Divi spital or , hours after neral Dir filled in l	1 Natural 5 Pending Investigation 3 X Suicide 6 Could not be determined Could	or To	tion (Street and Number or Rural Route Number, City Iven, State) Othe St. #103 Gaithersburg, M
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 2 should be detached for use as the burial -transcendent of the funeral directory page 3 should be detached for use as the burial -transcendent of the funeral directory page 3 should be detached for use as the burial -transcendent of the funeral directory page 3 should be 3 should be 4 should be			
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30 Name and address of names the smaller of the Carlo	O.C.M.E.	November 29, 2007
		enn Street, Baltimore, MD 21201	
Stat		<u> </u>	
Registra			
DHMH 17 Rev 1/200	1 ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

31. Date filed (Marth, Pay

32 Registrar's Signate

200

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month NOV 2)

32. Registrar's Signature

	200		1 - State Registrar 1. Decedent's Name (First, Middle, Last	State of Ma	ırylan	d / Depa	artmer rtifica	nt of H	ealth a Death	and M		Reg. No.	7	3 9 6 7 8	
A STATE OF THE PARTY	Physici /Medic Examin	cal	Rebecca E. 4a. Facility Name (If not institution, give 3642 Tyrol. Drive	Minson				Town, or	Location o	of Death		18, 2007	of Death	12:25 P.	М
===	Funeral Director		5. Social Security Number 6. Se 577–62–7641 10	x 7. Age	(In yrs.	last birthday) Yrs.		r 1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day November		9 Birthr	place (State or Fore	
	the Maryland 28a-f show	ector	10a. State 10b. County Maryland Prince Geo 10e. Street and Number	orge's	10c. Cit	y, Town or Lo	Sprin	edale				10g. Citizen of		10d. Inside City Lim 1. Yes 2 ☐ I	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is Madical Examinational by conflict at once.	by Funeral Director	3642 Tyrol Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 N N If Yes, Give Year or Dates:				dent of Hi	20774 spanic Origin, Mexican Specify:		ecify Yes or No Rican, etc.)	U.S.A	ce - Americ ck, White,	can Indian, etc.	
21215-0036	ied within 72 hou ygiene. nor than "natural it, the Medical E.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	+)	life.	kind of w DO NOT t	ork done d ise retired	luring mos) e Assi	stant		16b. Kind of B George Univers	usiness/In Washir ity Ho	ngtan	
Maryland	should be fit nd Mental H marked ott imatic even	To Be	17. Father's Name (First, Middle, Last) Milton SHor 19a. Informant's Name/Relationship (7)	ype, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	ar or Run	Loui	Maiden Surnar se Bundy er, City or Town		o Code)	
	ages 1 and 2 nt of Health a t: If item 27 is 7 or other tra		Mr. James T. Munson (F	Removal from State	C	3642 T Place of Disposemetery, creations Men	osition (Na matory or	me of other place	ө)		Marylan Pate 2007	d 20774 20c. Location Landove			
Baltimore,	permit. P Departme Importan eny injury		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens)	22	2. Name a	nd Addres	s of Facilit	y Rol		eral Home			
8760,	Physician /Medical Examiner behaviored and steep butian-transit	icai Examiner	23a. Paryl. Enter the disease, or composition, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each lin a. Hepatic Due to (or as a Due to (or as a c. Due to (or as a d	Fail: a conseq tic G a conseq	uence of): ancer Of uence of):	E Brea	st						Interval Between Onset and Death	
.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Feta	Ideath 3	⊒Ectopic p ⊒ Other (s						ate of deliv	rery Day Year	
Records, P.	Physician: The law requires that the this certificate has been signed by the fall director, page 2 should be detach	by	Part II. Other significant conditions co	ntributing to death bu	ut not res	ulting in the u	ınderlying	cause give	en in Part I		10	Yes 2□No	3 ☐ Pro	the cause of death?)WN
Vital Rec	an: The law tificate has t tor, page 2 s	Be Completed	25. Was case referred to medical						26. Place	of Deat	24a. Was autop perfo	psy ormed? 2⊠ No	were autoprior to codeath?	opsy findings availa ompletion of cause 2[文No	of -
Division of Vi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To B	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	У	ER/Outpatie 28b. Time o Injury		28c. Injun Worl	90 4 □ Nu	ursing Ho	me 5X Resi	dence 6 ⊡Oti how injury occu	rred		
<u>N</u>	apital or Att ours after de neral Diract filled in by t		4 Homicide determined	28e. Place of Injubulding, etc	. (Specif	(y) 			16. date ar	nd place	City or To	wn, State)		ral Route Number,	
)	To the Hospital within 24 hours a To the Funeral Completely filled i	Medical		iner: On the basis of and manner sta	examina	ation and/or in	rvestigatio	n, in my op oc. Licenso D237	pinion, dea number	ath occur	red at the time,	date and place, 29d. Date signo	and due to	to the cause(s)	
4864	De.		30. Name and address of person who of Martin Weltz, MD 31. Date filed (Month, N3) Yea?	7525 Green	way (Center D	rive (elt, M	bryla	nd 20770)			
	Sta Regist		nuvz 7	2001	ecian.	M.	Sperk	and and							

			1- For State of Maryland / De	partment of Fertificate of	lealth and M Death		giene () () 7	39679
*	Physici	an	1. Decedent's Name (First, Middle, Last) Elizabeth J. Moss			2. Date of Dea Month 11		3. Time of Death
	/Medic Examin	the state	4a. Facility Name (If not institution, give street and number)	4b. City, Town, c	or Location of Death		4c. County of E	7
	LAMIN	g Å	St. Thomas More Nursing & Rehab	Hyatts	sville			e George's
4	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 7. Age (In yrs. last birt	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day 04/2	(0/1920 9.	Birthplace (State or Foreign Country) VA
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show real be notified at	or	DC Washi					1 ☑ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	t Country?
	th with		3105 24th St. NE	2001	.8		USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecrly Yes or No- Rican, etc.)	14. Race - / Black, V	American Indian, White, etc.
30	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Modical Examinat must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 9 Year or Dates:	1 ☐ Yes 2 🙀 No	Specify:		Specify: T	Black
9500-61212	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occup	pation		16b. Kind of Busin	
7	thin 7	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done e. DO NOT use retire	during most of work d)	ang		
	led wi		12	Clerk		- (F**		Government
and	uld be fil lental H rked otl	To Be	17. Father's Name (First, Middle, Last) Ira S. Moss		Irene		Maiden Sumame)	
Maryland	d 2 should be filed within th and Mental Hygiene. ?7 le marked other than "!? traumatic event, it a Mag		19a. Informant's Name/Relationship (Type, Print) Phenton B. Moss/ sister	alling Address (Street 3105 24th			or, City or Town, Sta	
saitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 le marked any Injury or other traumatic evente.		1 😾 Burial 2 □ Cremation 3 □ Removal from State F ^{cemetery} :	sposition (Name of crematory or other place nCOIn Ceme		Date L/27/07	20c. Location - City Brentwo	
Saltil	permit. P Departme Importan any Injur.		4 □ Donation 5 □ Other (Specify) 21. Signature ☐ ineral Service Licensee	22. Name and Addre				
	402 • 4		23a. Part 1. Errier the disease, or complications that caused the death. Do not	3401 Blade				Approximate
	Physician	6	shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	1/2 (4/2)	us versue	der Wi	rease	yeary
	Examiner		Sequentially list conditions, b.					
	ed sif	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury					
	xecut and al-tran	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
0/g	cate be executed physician and the burial-transif	dical E	d					
Ď	± 00 %	Medi	IF FEMALE.					
X Q	leath certifica attending pt d for use as f	lan/h		3 ☐Ectopic pregnancy	у		23d. Date of Month	f delivery Day Year
5	0 0 0	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)				
ŗ.	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	ven in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
ecords,	quires in sign	Completed by	Dementia, Cerebral Info	uction, l	ty ren	1 🗆 Y	res 2 ☑No 3[Probably 4 Unknown
O သ	law reas bee	piet	Jensian, Churme Rea	red insi	PARKER	24a. Was	an 24b. Wer	re autopsy findings available r to completion of cause of
Ľ	The ate h page	Com	Encephalopathy				rmed? dea	th? Yes 2 No
N I I I	ysician: is certific director,	Be	25. Was case referred to medical examiner?	100	26. Place of Deal			
0	Phy this al d	. To	1 ☐ Yes 2 ☑ √ 0	tient 30 DOA			dence 6 Other (Specify)
	ding th: : After s fune	tlon;	27. Manner of Death 1 Accident 28a. Date of Injury (Month, Day Year) 28b. Tim (Month, Day Year)	ry Wor	rk?]Yes 2 ☐ No	200. 2000.100 /	ingary cocurred	
DIVISION	er dea	Certificati	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f. Location (S City or Tox		or Rural Route Number,
2	urs affi rel Dir led in							
	To the Hospitel or Attending Ph within 24 hours affer death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.					
	To the To the Comp	Ă	29b. Signature and title of certifier	29c. Licens			29d. Date signed (A	Month, Day, Year)
	10		Juntle rell to	70	1367		Novema	104242007
100	E.		30. Name and address of person who completed cause of death (Item 23a) (Ty	De, Print)	isto cingle	el bly	attso; h	1816/20181
No.	Sta Registr		31. Date filed Wants Gey. Year 7 2007 Seem S. Spen	re la company de	7			

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 7										39680		
I	Physici		Decedent's Name (First, Middle, Last) Joseph K. 4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital				Michalek				2. Date of Death Month November 22, 2007 3. Time of Death 8:55 A				
	/Medic Examin							4b. City, Town, or Location of Death Ft. Washington				4c. C	4c. County of Death Prince George's		
Ī		Irector	5. Social Security Nu 577–90–6221	ımber 6. Sex		7. Age (In yrs. 48	last birthday) Yrs.	If Under 1 Year I		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day May 28,	, Year) 1959		Birthplace (State or Foreign Country) Washington, DC
			Usual Residence of 10a. State	10b. County	1	10c. Cit	ty, Town or Lo								10d. Inside City Limits 1 □ Yes 2√3 1€0
	n the Mi		aryland 10e. Street and Num	Prince Geor	.ge 5 Opper 1.			10f. Zip Code				1	10g. Citizen of What Country?		
ore, Maryland 21215-0036	ath wit	raiD	8403 Margate					20772			1 4	USA Race - American Indian,			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other than "naturel", or Items 23s or 28s-1 show ery Injury or other traumetic event, the Medical Examenational Department of	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	ed 2 Married	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2∰ No ve	1	Was Deci f Yes, sp 1 □ Yes		spanic Origin, Mexican, Specify:	n? (Spec Puerto F	oify Yes or No- lican, etc.)		Black, Whit	
		Completed	(Speci		cation e completed) College (Vears	1-4or 5+)	kind of w	ent's Usual Occupation kind of work done during most of working O NOT use retired)				16b. Kind of Business/Industry Electronics			
		To Be	17. Father's Name (· · · · · · · · · · · · · · · · · · ·	halek					s Name	(First, Middle, et Ha			
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of								Jural Route Number, City or Town, State, Zip Code)				
			Kathryn Glyn 20a. Method of Disp	osition			Place of Disponentary, created	sition (N	ime of			boro, Mai	-	20/72 ation - City or	
Baltimore,			4 Donation	☐ Cremation 3 ☐ F "5 ☐ Other (Specify)		State _	surrectio	on Cen	etery	11	1/28/:			ton, Mai	•
Ba			21. Signature Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745												
	Physician but sicien and but sicien and but sicien and sicien and sicien and sicien and sicien site sicien site sicien sicien sicients sic		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition												
			resulting in death)	nditions [Due to (or as a consequence of):										
		Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	rlying Injury	Cue to (or as a consequence off:										
8760,		ai Exa	resulting in death) L	ast	Due to (or as a consequence of):										
vision of Vital Records, P.O. Box 6	tificate ig physi es the l	edicai			d								78		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 □ Live I 4 □ Preg	yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Unknown							23d. Date of delivery Month Day Year		
		<u>م</u>	Part II. Other significant conditions contributing to death but no Lucian Sections s									23e. Did tobacco use contribute to the cause of death? 1 Yes 1470 3 Probably 4 Unknown			
		Completed	Jea.	(,ing -	lys function.							autop perfor	24a. Was an autopsy prior to comple death?		utopsy findings available completion of cause of
		Be	25. Was case reference examiner?		26. Place of Death (Check only one)										
		tlon: To	1 ☐ Yes 2 ☐ 27. Manner of Death 11. ☐ Natural 2 ☐ Accident	Q110	28a. Date		ER/Outpatie 28b. Time o Injury		28c. Injury at Work?		2			e 6 Other (Specify) njury occurred	
		Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Loc							ocation (Street and Number or Rural Route Number, ity or Town, State)			
		edical C													
		Me	29b. Signature and	title of certifier	complet to cause of death (Item 23a) (Type,			29c. License number OY2955 Printy Edgar Potter MD				29d. Date signed (Month, Day, Year)			
	0		30. Name and addre	ess of person to o							2 7 . WD	ton. Md			
	L'	1	//	70) K	0,75	ston	Hed.	H	- 20	a 84.	-5	ton.	M	el a	20744
	Sta Regist		31. Date filed (Mon	1 2 6 2007	Te.	Registrar's Sign	Spen	de la							

DHMH 17 Rev 1/2001

Physician /Medical Examiner death certificate be executed for use as the burial-tran attending physician Box 68760 signed by the law requires that the ئە Records,

Mittelly roler, frank

or Vital

Division

or Attending Physician:

has certificate director, this funeral After

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination.

/Medical

Direct

Funeral

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Completed

Be

2

Examine

Physician/Medical

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Completed

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Certification:

IF FEMALE: DEMENTIA

2 Accident

3 Suicide

29a. Certifier (Check only

4 ☐ Homicide

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of pertifier

6 Could not be determined

29c. License number 6 6 6 6 6

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LEUNG-DOON WONG, ANDREW

8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

Registrar

31. Date filed (Month, Day, Year) NOV 27



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	ryland / De _l <i>C</i> e	partment of Health and ertificate of Death		giene 007	39682
	ş/-	1. Decedent's Name (First, Middle,	, Last)			2. Date of De Month	ath Day Year	3. Time of Death
Physici /Medic		Barbara Michels					r 26, 2007	M
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of Dea	th	4c. County of De	ath
	. 1	7317 Eden Brook 5. Social Security Number		(In yrs. last birthda	Columbia V) If Under 1 Year If Under 24 Hrs	S 9 Date of Bin	Howard	
Funeral Director			1 □ M 2 X □ F	Yrs	Months Days Hours Min	. (Month, Da		irthplace (State or Foreign Country) New York
		088-26-1500 Usual Residence of Decedent		74		OCLOBE	r 30, 1933	New TOLK
arylan ehow		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
Ba-f	Director	Maryland Howa	ırd	Columb	oia			1 □Yes 21 No
or 28	Dire	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	Country?
ours after death with the Maryla el', or iteme 23a or 28a-f ehov Examinar must be notified at		7317 Eden Brook	Dr. #703	use in H.C. 14	21046	Canada Van as Na	USA	nerican Indian,
Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed Forces?		 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 	rto Rican, etc.)	Black, Wh	
urs af	þ	3 □Widowed 4 □Divorced	ed 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify:	White
ified within 72 hours after death with the Maryland Hygiene. Hygiene. The Maryland Sa or 28e-f ehowent, the Medical Executor must be notified at	Completed	15. Decedent' (Specify only highest	's Education		edent's Usual Occupation ve kind of work done during most of wo	ndkina	16b. Kind of Busines	s/Industry
be filed within 72 ho tat Hygiene. d other then "natu	npie	Elementary/Secondary (0-12)	College (1-4or 5-	life	. DO NOT use retired)	,,,,,,,,		
bed w		42 Fate de Name (61-14 14/44)	4	Home	emaker	(CiA & Alid-U	Own Home	
- m	Be	17. Father's Name (First, Middle, L	_ast)				Maiden Sumame)	
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental Mental and Mental Ment	ဥ	Harry Tavel 19a. Informant's Name/Relationsh	in (Type Print)	19h Ma	iling Address (Street and Number or F		er City or Town State	Zin Code)
permit. Pages 1 and 2 should be Department of Health and Mental Important: If tem 27 le marked eny injury or other traumatic en <u>once.</u>		Harold Michels/			Eden Brook Dr. Co			, 2.0 0000)
t Hea		20a. Method of Disposition		20b. Place of Dis		Date	20c. Location - City of	or Town, State
Page lent o nt: If ry or		1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			ore Cemetery Nov	28, 200	St. Alba	ıns. NY
permit. Departm Importa eny inju		21. Signature of Funeral Service L	icensee		22. Name and Address of Facility Hi			
3 88 5 5 5		Nancy A	, Vercan	ve :	11800 New Hampshir	e Ave, S	ilver Spri	ng, MD 20904
		23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused tonly one cause on each line	the death. Do not e e.	enter the mode of dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a.	Met	astatic Breast Ca	ncer		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
	-	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	consequence of):				
uted i	Examiner	cause. Enter Underlying Cause (Disease or injury		4,				
be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):				
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rtificate ng phys	Medical	IE EEMAI E	d				da us	
ath certificate ttending physor use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	☐ Fetal death	B ∐Ectopic pregnancy		23d. Date of d	
ne death certificate the attending physhed for use as the		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No		☐ Fetal death	B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of d Month	lelivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39683 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MORELAND Day **Physician** 1500 M AYL 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Mandrin Chesapeake Hospice House <u> Anne Arundel</u> Harwood If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 24,1932 Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Maryland 216-30-1176 74 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel Harwood 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4420 Owensville Sudley Road 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No If Yes, Give 1955–57 Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: White 3 Widowed 4 Divorced "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M Administrator State of Maryland 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Moreland Allene L. Leatherberry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne A. Klien / Sister 7736 Deforest Dr. Chesapeake Beach, MD. 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Its
any Injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Church Cem. 11-26-07 Lothian, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain Physician 6 mos disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturai 2 Accident 5 ☐ Pending investigation HOUGE 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIGHWAY ANNAPOUS MO 21401

State

31. Date filed (Month, Day, Year)

ICHAEZ

J. LatenTA 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:17 Lois Mae Meiklejohn November 22, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis Anne Arundel 177 Acton Road 8. Date of Birth (Month, Day, Year March 16, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Year) 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 XF 214-18-7061 84 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Annapolis 1 XYes 2 No Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 U.S.A. 177 Acton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2XXXIII Specify. Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file iment of Health and Mental Hitant: If Item 27 Is marked oth Be Elizabeth Carr Thomas Miller ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Arnold, Maryland 1196 Palmwood Court Thomas Meiklejohn/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If Ite any Injury or oth WBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 11/27/2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jon M. Taylor Funera Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 odd 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) years Sease 10 Coronar **Physician** /Medical Due to (or as a consequence of Examiner bras a consequence of). ten SIOF 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examiner by the attending physician and stached for use as the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
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1 Yes No
9 Unknown 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner Other: 3□ DOA 1 Yes 1 Inpatient 2 ER/Outpatient P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

or Vital

Division

State Registrar 31. Date filed (Month, Day, NOV 2 6 2007

29b. Signature and title of certifier

and address

Pagistrar's Signature Sour

o completed cause of death (Item 23a)

29c. License number

29d. Date signed (Month, Day, Year)

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		•	For State Registrar	Olato of Marylo		ertificate of			No.2007	39685	
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	Examin	-	4a. Facility Name (If not institution, giv Mandrin Hospice			4b. City, Town, o	or Location of Death		4c. County of Dead		
	Funeral Director		5. Social Security Number 6. S 217–30–3027		rs. last birthday Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo 10/27/192	ear) 9. Birt	thplace (State or Foreign ountry)	
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	ath with the 23a or 28 ust be no	ral Director	10e. Street and Number 708 Oser Drive			10f. Zip Code 2103			. Citizen of What Co		
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Married 3 Ծ Widowed 4□ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☒ Yes 2 ☐ No W If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🂢 No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:		
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State of Marvland / Department of Health and Mental Hygiene 2007 39686

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Physic edical Exam				2. Date of Death Month December		3. Time of Death 1450 hrs
		4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death		4c. County of Death	
Funera		Johns Hopkins Hospital 5. Social Security Number 6. Sex 17. Age (In vrs. last birthday)	Baltimore	1	Baltimo	
Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 236-74-2225 1 M 2 F 59 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bir Foreig Co	
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hygiene. unit. If them 27 is marked other than "natural", or items 23n or 28n-f show any or other traumatic event, the Medical Examiner must be notified at once.	ai		Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA	can Indian, Black,
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altim nit. Pa Parlmen Sortant		4 Donation 5 Other Specify: Hagerstown 21. Signature of Funeral Sprvice Licensee 22. Na	Crematory 12	/7/07	Hagerstown	, Maryland
The Dept.		1 - white	ame and Address of Facility MINN 5 E. Wilson Blv	d. Hage	retown Md	. 21740
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac or	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
taminer		Immediate Cause (Final disease or condition resulting in death) a. Acetaminor hen toxicity Due to (or as a consequence of):				Death
	L	Sequentially list conditions, b				
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
isi_ ee ky	Exar	events resulting in death) Last Due to (or as a consequence of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	d. X UNPENDED AMENDED CO. C.				
760, icate by physicate but the but		IF FEMALE: 23b. Was decedent pregnant in the), 1/15/08 TT		23d. Date of delivery	
Box 687 he death certification of the attending placed for use as the	ician	past 12 months? 2 Feta	ncy	Month D	ay Year	
Bo he deat y the at hed for	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	er (Specify)			
ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		2 No 3 Prob	he cause of death? ably 4 Unknown
rds, require been si hould b	Completed			24a. Was an	24b. Were aut	opsy findings available
of Vital Records, ag Physteian: The law requin ther this certificate has been si meral director, page 2 should t	omp			autopsy perform 1 ✔ Yes 2	ed? death?	ompletion of cause of
	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check of		No 1 Ye	S 2 No
f Vid	2	1 ✓ Yes 2 No Inospital: 1 ✓ Inpatient 2 ER/Outpatient		400,000	esidence 6 Other:	
	tion:	1 Natural 5 Pending (Month, Day, Year)	1 Ves 2 No	28d. Describe ho	w injury occurred	
Division pital or Attendir ours after death eral Director: A	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be Find 12/5/2007 Find 7:50 28e. Place of Injury - At home, farm, street,	amı A I	unk 28f. Location (Str	eet and Number or Rur	al Route Number, City
Di spital	Cert	4 Homicide determined (Specify) house		or Town, Stat	te)	MD 117 Hagersto
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre one) 2 Medical Examiner: On the basis of examination and/or investigatio	d at the time, date and place, and	due to the cause(s) and manner as state	d
To Com	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		Pantle I wo that I mo	O.C.M.E.		December 6, 200	
		30. Name and address of person who completed cause of death (Item 23a)				
St	ate		Penn Street, Baltimore, M	D 21201		
Regist	rar	31. Date filed (Month, Pay Year) 2007 32 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^D2^y5, 2ď 07 November 7:31 P M Robert John McMahon, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 12624 St. James Road Rockville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □XM 2 □ F Director Sept 20, 1928 New Jersey 158-20-7836 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 28a-f sh notified 1 ☐ Yes 2X No Director MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or iral", or items 23a Examiner must b 12624 St. James Road 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examines 1 XYes 2 No If Yes, Give 1951-52 Year or Dates. 1 Never Married Married 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Certified Public Accountant</u> Nuclear Consulting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Stewart Robert John McMahon, Sr. ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen K. McMahon/wife 12624 St James Road Rockville, MD 20850 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/27/07 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 years Prostate Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or in Jury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph I for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performe 2 XNo 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within ?

To the comple 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

State Registrar Manish Agrawal, M.D. 31. Date filed (Month, Day, Year) NOV 2 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D62234

9707 Medical Center Dr. #300 Rockville, MD 20850

November 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Virginia Hester NEWHOUSE 2007 3 AM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | AUG 2, 1916 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 235-22-4269 91 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No WV Hardy Moorefield Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 26836 306 Holly Ave USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 Is marked of any Injury or other traumatic evenoce. Glaspy Valentine Wolfe Josephine Southerly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Byrd - Daughter 196 Monarch Ct., Martinsburg, WV 25403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages * 1 Burial 2 □ Cremation 3 □ Removal from State Moorefield, W 11/20/07 Olivet Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fraley Funeral Home 145 N. Main St., Moorefield, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Arterio Schediz Immediate Cause (Final Candro Varales Divies **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and this indicated events and this indicated events and this indicated. Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ding physician and see as the burial-tra Division or Vital Records, P.O. Box 68760, 2 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dines 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 201 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director; 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (alt mo P10819 NOV (9, 201) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-739-7100 21740

DHMH 17 Rev 1/2001

State

Registrar

Hagerstown, MD

340 Mill

DEC 1 1 2007

Datta 31. Date filed (Month, Day, Year) Street

Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:20 NOV". 17 Pay 2007 Par **Physician** WARREN NOKES VIRGIE REBECCA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 23,1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X Wash. DC 77 Director 223-36-5396 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notifled at Silver Spring Montgomery 1 ☐ Yes �☐ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene, and the firen 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be r 20906 U.S.A. 14124 Whispering Pines Ct, #11 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ X Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Selah Edmunds 2 Nathaniel Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 14124 Whispering Pines Ct, #11, Silver Spring Barbara Demar (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopartion 5 ☐ Other (Specify) 11/23/07 Riverdale Pk Crem Riverdale, MD 4□Dopatjen 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21/Signatura of Funeral Secrete Liver see 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonic Bilateral **Physician** disease or condition resulting in death) /Medical Examiner spiratory Sequentially list conditions, if city, reading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit The law requires that the death certificate be executed P.O. Box 68760. Physician/Medical as t attending p for use as IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No
9 □ Unknown 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month 5 Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate ha autopsy 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident (Month, Day Year) Injury 5 | Pending 1∏Yes 2∏No investigation within 24 hours after death To the Funeral Director; completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/21/07 3212000 20. Note and addre of retion who completed cause of death (Item 23a) (Type, Print) Prince Plate Prive Kirkeald 40 10181 31. Date filed (Month, Day, Year) egistrar's Signature State

Registrar

NOV 27

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09097 State of Maryland / Department of Health and Mental Hygiene Julian Alexander Nalos Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Deat Physician/ Decedent's Name (First, Middle,Last) 1410 hrs November 24, 2007 Medical Examiner Alexander Julian Nalos 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hospital Rethesda 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign Days Months 1988 Country) D.C. Oct. 21, Director 220-21-6095 $_{1}[\mathbf{X}]_{\mathsf{M}}$ 19 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 x No 28a-f show items 23a or 28a-f sho Silver Spring Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 13106 Nordic Hill Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Married Yes è permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene.
Important: If then 27 is marked other than "natural", o injury or other traumatic event, the Nedical Examiner. If Yes, Give Year 1 Yes 2 x No specify: Specify Asian 3 Widowed Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student Education 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander T. Nalos Alfoncitafe J. Frias Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore, MD 13106 Nordic Hill Drive, Silver Spring, MD 20906 Alexander T. Nalos/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Dec. 1, 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Donation 5 2007 Silver Spring, Maryland Other Specify Name and Address of Facility Trancis J. Collins Funeral Home Inc. 22. Name Frai 500 Signature of Funeral Service Licenses ohn Kyle Colly MYA MD 20901 Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical physician the burial -UNPENDED AMENDED Box 68760. 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day by the attending posterior Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 2 Yes 2 ✔ No 3 Probably 4 Unknown Completed s peen s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes certificate 24 hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi-stely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Inpatient Residence 6 Other: DOA Nursing Home 5 2 V ER/Outpatient 3 2 No 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury Certification: Driver auto fixed object collision Nov 24, 2007 1029 hrs 1 Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Randolph Road & Denley Road, Wheaton , Md. determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

2007

ORIGINAL

gistrar's Signatu

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

November 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** KATHLEEN LYNN PRICKETT DECEMBER 2007 11:00p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12721 Bloomfield Rd. Kennedyville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 1946 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Pennsylvania 61 181-36-6715 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 ia markad other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 TXYes 2 □ No Director NJ Burlington Lumberton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Fostertown Rd. 08048 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Agricultural Assistant Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fil h and Mental H 7 **ia markad otl** Charles Kocmund Edna Matherson Pages 1 and 2 should I nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Phillip D. Prickett (husband) 186 Fostertown Rd. Lumberton, NJ. 08048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State = ō permit. Page Department of Important: If any injury or once. St. Paul's Luth Cem 12/10/07 Hainesport, NJ. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Furties Service License 22. Name and Address of Facility 438 High St. M00510 Perinchief Chapels Mt. Holly, NJ.08060 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Amyotrophic Lateral Sclerosis year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signed should be c 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【X No autopsy performed? certificate 1 Yes 2X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Special Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Tes 2X No s efter dec. 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral L 1[X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120 Spee Road Chestertown, MO 21620
Registrar's Signature on who completed cause of death (Item 23a) (Type, Print) 36 State Registrar

7. Age (In yrs. last birthday)

66

Physician	
/Medical	
Examiner	

4a. Facility Name (If not institution, give street and number)

5. Social Security Number

577-56-6776

Washington County Hospital

1 M 2 □ F

Funeral Director

Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County Maryland Mongomery Silver Spring **Funeral Director** 10f. Zip Code 10e. Street and Number 9309 New Hampshire Avenue 20903 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) Be ပ William Luke Parran Floyetta Berry 19a. Informant's Name/Relationship (Type. Print) Edith Parran Penn - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 21. Signature of Funeral Service License 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HIV Disease Physician /Medical Due to (or as a consequence of) Examiner Failny nyonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? this certificate 1□ Yes 2√2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ Il Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Vovember 22, 2001 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Dec. 18, 1940 Maryland 10d. Inside City Limits 1√2 Yes 2 □ No 10a. Citizen of What Country? United States Race - American Indian, Black, White, etc. Specify: Black. 16b. Kind of Business/Industry N/A18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Flint Hill Rd Silver Spring, MD 20906 20c. Location - City or Town, State Nov 29, 2007 Landover, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death

1823 M

State Registrar 1126 OPAI Court 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, maryland 21740

11-23-2007

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

31. Date filed (Month, Day, Year) NOV 2 7

Waseem

Physician /Medical Examiner Examine

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Physician

Examiner

Funeral

Director

Examiner must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

3altimore, Maryland 21215-0036

/Medical

physician this After t

Physician/Medical

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Completed

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Medical Certification:

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY 25. Was case referred to medical examiner? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10 118

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Registrar

29b. Signature and title of certifier

you FI, CHEVERLY 32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Elizabeth 230 A 2007 /Medical 4a. Facility Name (If not institution, give street and number)
79 Racine Read 4b. City, Town, or Location of Death 4c. County of Death Examiner Jorth Eas (eci If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🛣 F Director 254-09-7907 91 Nov. 27, 1915 Alabama Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Ceci1 1 ☐ Yes 2X No Director Maryland North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r 21901 79 Racine Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No Army If Yes, Give Year or Dates 1943-45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) <u>12</u> <u>Telephone Operator</u> <u>Telephone</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked otf Jury or other traumatic even Be William Clarence Archer Ruby Cook Andrews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara J. Hayes / Daughter 79 Racine Road, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Mayerdale Crematory 23, 2007 4 □ Donation 5 □ Other (Specify) Newark, Delaware 21. Si, aturn of Funeral Service Legensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** Mixed >10 years /Medical Due to (or as a consequence of): Examiner Alzhemers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Vascular Due to (or as a consequence of): Physician/Medical tension IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2,**X**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 X No Hospital: Certification: To 1 Tes 1 !npatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death Natural

The law requires that the death certificate be executed burial-tran or Vital Records, P.O. Box 68760, attending pl page 2 should

this

After

24 hours after death.

within 2

filled in by the

Medical

or Attending

Hospital

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier Mile D. Heuser, ms

5 Pending investigation

6 Could not be determined

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene Street

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PERSSGITIN. Year SXANDER 5:00 PM NOV 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Sept 26, 19 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□ F 1916 South Carolina Hours 213 07 9759 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 ☐ Yes 2 ☐ No Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21043 4701 Bounty Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 ☐ Divorced White "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Welder Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H Item 27 is marked ot r other traumatic ever Lawrence Perseghin Julia unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4713 Wigglesworth Court Ellicott City, MD 21043 Gerard A. Perseghin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: if its any injury or of once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 12-7-2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA 48 hoors /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

✓// Yes 2 No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 □ Natural 5 Pending investigation NOV 15 2007 10:08M PAPISHT 2 Accident FELL FROM 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) SLLI LOTT CITY, 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide House n 24 hours aft le Funeral Di letety filled ir 4701 BOULTY COWET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To th within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOU 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21044 COLUMBIA,

State Registrar

31. Date filed (Month, Day, Year)



M.D.

LITTLE

07-09352 Marsha Pinder		Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	Legible.
	1- P	For State Amend 4a, 4b per phys. Certificate of Death	Reg. No. 2007 39698
Physician	1/ 1	Decedent's Name (First, Middle, Last) 2. Date o	f Death 3. Time of Death Day Year 0130 hrs
Medical Examine		ia. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
		Dorchester Memorial Hospital Borchester Easton	Talbot
Funeral	5	Months Days Hours Min.	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	ø	Journal Residence of Decedent	ch 15, 1960 Country) Maryland
any	-	Oa. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	ğĹ	MD. Dorchester Cambridge	1 Ves 2 No
or 28a	Director 1	810 Slacum Street 2/6/3	10g. Citizen of What Country? USA
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho	<u>e</u> 1	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian, Black,
or items 23a	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.	
ral",	_ হ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes, 2 W No specify: or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done	Specify: Black 16b. Kind of Business/Industry
2 hour	eted -	Elementary/Secondary (0-12) College (1-4 or 5+)	
0036 within ene.	Completed	12 Nurse's Aide	Health Care
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ပ္တို 1 မွ	17. Father's Name (First, Middle, Last) Paul Lennord Pinder 18. Mother's Name (First, Middle, Last) Lillian An	na Mae Molock
212 212 Sould be I Ments i mark	2 - 2 -	19a, Informant's Name/Relationship (Type, Print) 4	te Number, City or Town, State, Zip Code)
MD and 2 sho shifth and 2 sho m 27 is	L	Shanna R. Farrare 503-B Hemlock St. Sal	Spury Mary land 21804 200' Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter		crematory or other place)	
Itim it. Pag uriment orfants		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name an Address of Facility (1.10)	PARNECK, MU
Balti permit. Departu Importi	-1	Janelle C. Serry Sig Washington St.C.	ambridge Maryland 21613
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kaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):	Death
_		Sequentially list conditions, b	
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
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OX 68760, eath certificate be ex attending physician for use as the burial		F FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box 68760, e death certificate be the attending physic ed for use as the bur	cjan/	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Month Day Year
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ecol he law ite has	dwc	1	performed? Yes 2 No 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law require standed death. al Director: After this certificate has been side in by the function page 2 should be a	S E	25. Was case referred to medical examiner?	
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Dir spital c	$c_1 \vdash$	4 Homicide determined (Specify)	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	<u>'</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the constant of the	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To To Com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		Jaste Gogius O.C.M.E.	December 3, 2007
		30. Name and address of person who complete Juse of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1
Sta	ate 3		
Registr	rar	31. Date filed (Month, Day Year) 7 2007 32. Restrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23pt Il ineb per PHYS C874 12/11/07 WS
State of Maryland Department of Health and Mental Hygiene

1- State Registrar amend items 9,10b per fh 887 Certificate of Death

Reg. N2 0 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8^{Day} **Physician** Month Nov. 2007 Florence Romaine Parman 1:40 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Health Care Montgomery Village Montgomery Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 Yrs. Director 93 Dec. 18, 1913 Pittsburgh, 192 03 6582 Usual Residence of Decedent the Maryland 10b. County
Montgomery 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD Gaithersburg Contgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code with ms 23a or 19939 Buhrstone Dr. USA 20886-1016 Funeral death 12. Was Decedent Ever in U.S Armed Forces? "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Homemaker Own Home f Health and Mental Hygie Item 27 is marked other t other traumatic event, th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Rice 2 Max Morman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Kline Blvd., Frederick, MD 21701 Department of Health Important: If item 27 any injury or other tr Gale Klupt, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shomayim Cem Shaarai 11/9/2007 Lancaster, PA 21. Signature Juneral Service Licen-22. Name and Address of Facility 17603 Venuer Fred F. Groff, Inc., 234 W. Orange St., Lancaster, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAILUGZEZ TO THERIVIE /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 (★No page 2 s autopsy performe certificate 2 No the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Warsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this he Funeral Director: After the Pulperal Director of the funeral Director of the funeral bletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifie 11-8-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Anushiravan Dadgar, D.O., 9715 Medical Ctr., Dr., Rockville, MD 20850 39. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Donald H. Reed /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/20/1933 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**™**M 2□F WV Director 578-42-5376 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show mit: If Item 27 Is marked other than "natural", or items 25a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20020 2114 T Street, SE by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Black 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Government Transit Operator 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alease Lofton Edwin Reed 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2114 T Street, SE, Washington DC, 20020 Daryl K. Reed / Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/26/2007 Brentwood, MD 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 21. Signature of Funeral Service Lie ensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 uhry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con-e-port f): Examiner noumon Sequentially list conditions Due to (or 25 a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 7 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ To the Funeral Urector: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) anenmanner stated 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 1/2001

State

cause of death (Item 23a) (Type, Print)

GA

Registrar's Signature

UY

2007

31. Date filed

11/17/07.

4701 Randolph Fd #216 Rockville MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	for State Registrar	State o	f Marylan		artment of I rtificate of				giene Reg. No 2 (007	39699
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	/Medi		Alfred V. 4a. Facility Name (If not institution	Rosser	mber)		4b. City, Town, or Location of Death		11		2007 nty of Death	2:27 P	
	Exami	ner			ŕ		4b. Oity, Town, t	or Location	OI Deall			tgomer	17
			Montgomery 5. Social Security Number	General Ho		lant hirthday	Olney If Under 1 Year	If Linder	r 24 Hrs.	8. Date of Birt			,
b	Funeral Director		223–38–0614	1.23 M 2 ☐ F	7. Āge (In yrs. I	Yrs.	Months Days		Min.	(Month, Da	y, Year)		place (State or Foreign ntry) nburg, VA.
	P .		Usual Residence of Decedent		1.0.00								
	rylar how	_	10a. State 10b. County	/	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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	r 28	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Coul	ntry?
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	fter iter	Fur	1 Never Married 2 Mar	Armed Fo	rces?		If Yes, specify Cub	oan, Mexica	n, Puèrto	Rićan, etc.)	E	Black, White,	etc.
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	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at		12th. 17. Father's Name (First, Middle	Last)		Main	tenance			e (First, Middle,	Unkn Maiden Suri		·
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailis	ng Address (Street	t and Numb	er or Rur	al Route Numb	er, City or To	wn, State, Zip	Code)
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ore	ges 1 ar t of Hea If item 3		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemoval from		lace of Dispo emetery, cre	sition (Name of matory or other pla	асө)		Date	20c. Location	on - City or To	own, State
Baltimore,	permit. Pages : Department of H Important: If ite any in ury or of		4 Donation 5 Other (antico	Nationa	1	11-2	3-07	Trian	gle, V	Α.
a	mit.		21. Signature of Funeral Service	e Licensee		2:	2. Name and Addre	ess of Facil	ity MA	rshall'	s Fune	ral Ho	me
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x 68760,	ertificate ling physi e as the l	Medical	IF FEMALE:	d.									
P.O. Box	at the death certific by the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b	come pf pregna pirth 2 Fetal ant at time of de own	I death 3	Ectopic pregnand Other (specify)	су			23d.	Date of deliving Month	ery Day Year
	res that iigned b		Part II. Other significant condit	ions contributing to de	eath but not resu	ulting in the u	nderlying cause gi	ven in Part	I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
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ō	Phys this al dir	은	1 Yes 2∏ No	1/2		ER/Outpatier	R 3 DOA	•	ursing Ho	me 5 Resid			fy)
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sio	Attending it death. ector: After by the fune	ati	Z	igation			M 1	Yes 2	No				
Division	s after de al Direct	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ninged Zoe. Flace	of injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office			28f. Location (S City or Tox	Street and Nu vn, State)	umber or Run	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the i Examiner: On the b and man	best of my know asis of examinat ner stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	time, date a opinion, de	ind place, eath occur	and due to the rred at the time,	cause(s) and date and pla	d manner as s ce, and due t	stated. o the cause(s)
	To the To the Company	Ž	29b. Signature and title of certific	er	11		29c. Licen	se number	-0		29d. Date sig	ned (Month,	Day, Year)
			V/44 /	Ull 1	HOSM	tall	at 1)1	005	99	14	11/1	14/2	
			30. Name and address of person	who completed caus	e of death (Item	23a) (Type)	Print)	01	. 1	0	20	- (,	^
_			30. Name and address of person	AWIN	1801	Fo	ince	Ph.	lip	Dr U	Herel	e M	
	3 01	te	31 Para illed (Month Parayear		egistrar's Sighal				1		1		

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11:52A M NOVEMBER 4, 2007 MARTON ROLLIN ROBINSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 600 E. GUDE DRIVE ROCKVILLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 61 Yrs. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 579-62-2848 1XIM 2 | F NOV. 2, 1946 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Rockville Director Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States of America 1008 Heritage Fields Ave Funeral 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armeu Polces: ↑ Yes 2 No If Yes, Give Year or Dates:1966-72 1 ▼ Never Married 2 Married 3altimore, Maryland 21215-0036 1∐Yes 2XTNo Specify Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Systems Engineer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Cleothra Reid Herbert Samuel Robinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1008 Heritage Fields Ave Rockville, MD 20850 Netherland Washington - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/07 Suitland, Maryland Lincoln Memorial Cem. 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy performe Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)Men's Shelter Hospital: 1 M Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 24 29d. Date signed (Month, Day, Year) 29c. License number ure and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2(0)

BRECKER

31. Date filed (Month, Day, Year)

NOV 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** ROMEM Meir 11:40 P M 2007 20, Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 79 Director unknown April 8, 1928 Argentina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Emek Isreel Kibutz Gazit Israel 1X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19340 Israel Kibutz Gazit Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Engineer the Department of Heath and Marial Hygin Important: If item 27 is marked other any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Ruemeser Bertha Schwartzman ပ 19a. Informant's Name/Relationship (Type. Print) Sylvia Romem / Spous 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romem spouse Kībutz Gazit , Emek Isreel, Israel 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Nov.22, 2007 Emek Isreel, Israel Kibutz Gazit Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Source Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner ly o cardio Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 > 400 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ ≥ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 2 ☐ Accident 28b Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number who completed cause of death (Item 28a) (Type, Print) David State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARGIE A. RITTER 2007 NOV Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional Medica If Under 1 Year Under 24 Hrs. Days Hours Min. Wicomico 5. Social Security Number Age (In yrs. 8. Date of Birth (Month, Day, Y 7-8-1951 9. Birthplace (State or Foreign last birthday Year) 1 □ M 2 🛱 F 56 MARYLAND 216-56-1236 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits LEWES 1 ☐ Yes 2 KINo DELAWARE SUSSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19958 22036 ROBINSONVILLE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantal Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF DELAWARE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LUTISHA MARSHALL HAROLD M. HOWARD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22036 ROBINSONVILLE RD, LEWES, DE. 19958

Date

LONG NECK RD, MILLSBORO, DELAWARE. 19966

11-26-07

22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD.

SAlisbury md. 21801

20c. Location - City or Town, State

FRANKFORD, DELAWARE

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: If item 27 is marked other than any Injury or other traumatic event, the Me

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

19a. Informant's Name/Relationship (Type. Print) MARK R. RITTER/ HUSBAND

5 Other (Specify)

3 Removal from State

2 Crema

ter the disease heart failure.

30. Name and address of person who

ENG DO

2007

SIMONA

31. Date filed (Month, Day,

20a. Method of Disposition

1 ☐ Burial

23a. Part1. Ente

4 ☐ Dopation

21. Signature of Funds

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical

attending physician as the nse ō signed by the at d be detached fo been has within 24 hours after death.

To the Funeral Director: After this certificate t completely filled in by the funeral director, page

the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending Physician:

the

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) CVD Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 200

20b. Place of Disposition (Name of cemetery, crematory or other place)
MELSONS CAPE
HENLOPEN CREMATORY

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line.

DHMH 17 Rev 1/2001

State Registrar

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Pleas	se Type or	Print in Bla	ck In	delible Ink.	Ensure A	II Copies A	re Legi	ible.	
ar	State o	of Maryland /	Depa Cer	artment of H	lealth and N Death	Mental Hygi	ene 0	07	39704
's Name (First, Middle	e, Last)	 				2. Date of Death Month		Year	3. Time of Death
ALJON	JANE	RI	DE	VOUR		NOVEMBE	,	2007	1805 PM
lame (If not institution, give street and number)				4b. City, Town, or	Location of Death				
THWEST	HOSFITAL			RANDA	NSTON		BA	LTIMO	RE
12-6501	6. Sex 1 ☐ M 2 ☐ K F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 10		Count	ace (State or Foreign ry) yland
ence of Decedent									
10b. County		10c. City, To	wn or Lo	cation				10	d. Inside City Limits
and Balti	imore	Gwy	nn	Oak					1 □ Yes 2 📉 No
and Number				10f. Zip Code		10	g. Citizen of	What Count	ry?
Campfield	d Road			21	1207		U.S.	Α.	
Status	12. Was Dec Armed Fo	edent Ever in U.S. orces?	13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - America	

WI */Medical 4a. Facility N Examiner 5. Social Se **Funeral** 579-Director Usual Resid 10a. State "natural", or items 23a or 28a-f shovedical Examiner must be notified at Mary Directo 10e. Street a 6811 Funeral 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: 9 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natun traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accountant-secretary/bookkedper meat packing co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winona Jackson Funkhouser H. Clyde Ridenour 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 28 Woodridge Lane, Syksville, Maryland Department of Health Important: If item 27 any Injury or other tr Rosser J. Pettit - executor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State November Paul's Cemetery 4 Donation 5 Dother (Specify) 20,2007 Clear Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 415 E.Wilson Blvd., Hagerstown, MD Immediate Cause (Final disease or condition resulting in death) Examiner

Physician /Medical **Examiner**

Physician/Medical

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Completed

Be

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Certification:

Medical

State

funeral

neral Director: / filled in by the fi

within 24 hours a To the Funeral L

9-HCD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass or injury that initiated events resulting in death) Last

. Decedent

Physician

,					Onset and Death
_a.	mumones				
	Due to (or as a consequence of):				
b					
- 12.5	Due to (or as e consequence of):				
c					
	Due to (or as a consequence of):				
d					
			5 (S.E.)	1	
23c	. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of de	,
		Other (enecify)		Month	Day Year

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2. ☑No
9 ☐ Unknown
Part II Other significant condi

9 Unknown

tions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

HO-PITAT

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

21740

white

24a. Was an autopsy 2 🗷 No 1∏ Yes

25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:
27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a.

6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number D0059736

NORTHWEST

29d. Date signed (Month, Day, Year) november 2007 16

5401 OLP COURT ROAD

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

TZPATRICIL WATSON DEBJRAH 31. Date filed (Month, De)

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	Maryland / De	epartment of H Certificate of I		Mental Hygi	ene 2007	39705	
	27	-	Registrar 1. Decedent's Name (First, Middle, Last)		erillicate of t	Dealli	2. Date of Deatl		3. Time of Death	
	Physici /Medic		Dorothy M. R	obinson			Month	Day Year	22145M	
	Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of Death		4c. County of Dea		
		*	Calvert Manor 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho		ng Sun	8. Date of Birth	Ceci	thplace (State or Foreign	
	Funeral Director		163-01-6314 1□M 2XF	92 Yrs	Months Days	Hours Min.	(Month, Day, 2/19/1	Year) Co	nsylvania	
C. S. Carlon	pu ,		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	r Location					
	farylar show	or	10a. State 10b. County MD Cecil		ng Sun				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the N 28a-i	Director	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Co	24	
	h with	al Di	1881 Telegraph Road		219	911		USA		
	r dear	Funeral	11. Marital Status 12. Was Decer Armed For	dent Ever in U.S. ces?	13. Was Decedent of H		pecify Yes or No- partican, etc.)	14. Race - Ame Black, Whit		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes : If Yes, Give 3 ※ Widowed 4 ☐ Divorced Year or Da	2X No	1 ☐ Yes XXNo	Specify:		Specify: W		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ted t	15. Decedent's Education	16a. De	ecedent's Usual Occup	ation		16b. Kind of Business	/Industry	
215	ithin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+)	Give kind of work done of fe. DO NOT use retired		king			
	Hygier Hygier Her th		17. Father's Name (<i>First, Middle, Last</i>)		Homemake		ne (First, Middle, N	Hom-	e	
and	d be f ental h ked ol c eve	To Be	Norman Kriebel				erva Ny	,		
Maryland	should be f and Mental I s marked of umatic eve	ř	19a. Informant's Name/Relationship (Type. Print)	19b. M	lailing Address (Street a				Zip Code)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Kenneth Truman (son)		Highland					
Ore	Pages 1 ment of H ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from S	20b. Place of Di cemetery,	isposition (Name of crematory or other place	1		20c. Location - City or	Town, State	
altimore,	permit. Page Department of Important: If any injury or once,		4 □ Donation 5 □ Other (Specify) 21. Signature of Funefal Service Licensee		22. Name and Addres		/27/07	Pottsto	wn, PA	
Ba	Dep Imp any		1 - 1	€C0442	D	7 1	Home of	Newark	DD 10700	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear the disease of the cause of	used the death. Do not ach line.	enter the mode of dyin	ISKI HI Ig, such as cardiad	or respiratory arre	Newark,	DE 19702 Approximate Interval Between	
*	Physician		Immediate Cause (Final disease or condition resulting in death)	ulti-org	an Fail	ere			Onset and Death	
f s	/Medical Examiner		Due to (c	or as a consequence of):						
	7 -	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	or as a consequence of):	:					
	ocuted nd transit	Examiner	that initiated events							
60,	ficate be executed physician and is the burial-transit		Due to (c	or as a consequence of):						
68760,	ficate physics the t	edical	d							
Box	res that the death certific igned by the attending p be detached for use as			come pf pregnancy	3 □Ectopic pregnancy	,		23d. Date of delivery		
O. B	e deat he atte	Physician/M		ant at time of death	5 Other (specify)			Month	Day Year	
Д.	that the		Part II. Other significant conditions contributing to dea	ath but not resulting in th	ne underlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?	
Records,	puires r signe	d by	Suppis Accordany.	to UTT	Dneum	one	1 □ Ye	s 2 p No 3□P	robably 4 □Unknown	
O O	s beer s shou	olete	Hr of CVA		1		24a. Was ar		utopsy findings available	
	Physician: The lav this certificate has ral director, page 2:	Completed					autops perforn 1 Yes 2	ned? death?	completion of cause of s 2 □ No	
Vita	ctan:	Be	25. Was case referred to medical examiner?		lou.		th (Check only one			
	Physic this c	۲.	1 Yes 2 No Hospital: 1 □ In 27. Manner of Death 28a. Date o	npatient 2 ER/Outpa		4 Mursing H	ome 5 Reside	nce 6 Other (Spe	ecify)	
O	th. :: After	tion		h, Day Year) Inju	iry Worl	k? Yes 2 □ No	200. Describe no	w injury occurred		
Division or	r Atter	Certification:	3 Suicide 6 Could not be 28e. Place of	of injury - At home, farm, ng, etc. (Specify)	, street, factory, office		28f. Location (Str. City or Town	eet and Number or R State)	ural Route Number,	
ō	oital or urs afte rral Di									
	Hosp 24 hou Fune etely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the la 2 Medical Examiner: On the ba and mann	isis of examination and/o	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	luse(s) and manner a ate and place, and du	s stated. e to the cause(s)	
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Med	COL City of the set of		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)	
			M. Farkes	17	1 15	314	1	10 Nembe	26,2007	
	2		30. Name and address of person who completed cause	of death (Item 23a) (Ty	rpe, Print)	1/ P.	1 54	= 1/7	~ 26, 2007	
	Sta	te	31. Date filed (Month, Pay, Year) 32. Re	wistrar's Signature	11 ce, 133	N. pride	K 11. E	1K10n		
	Registr		NUV 2 7 2007	Value S.	(DAYE)					

P.O. Box 6876077 Division or Vital Records,

Baltimore, Maryland 21215-0036 Physician **Examiner** The law requires that the death certificate be executed or Attending Physician: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ST NO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral (27. Manner of Death 11 Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number emper ewman mo 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		rtificate of			gienez 0	07	39/0/
	Physici		1. Decedent's Name (First, Middle, Las Rubbie	Marie	Kreh	Sauer		2. Date of De Month Decembe	Day	00 7	3. Time of Death 6:23 p M
	/Medic		4a. Facility Name (If not institution, give	street and number)			r Location of Death			y of Death	
			2906 Byron C	ourt		Abi	ngdon		На	arford	d
F	uneral		Social Security Number 6. Security Number	TM OFFE	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	lace (State or Foreign ntry)
Di	irector	9	217-28-7345	7:	3 Yrs.			10/9/1	934		MD
and	M T		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation			A-44-4-	1	0d. Inside City Limits
Mary	f sho	to	MD Harford		Abingdon						1 ☐ Yes 2 📉 No
η the	r 28a notii	Director	10e. Street and Number		HDTIIRGOU	10f. Zip Code		·	10g. Citizen of	What Coun	ntry?
th with	23a o st be	a D	2906 Byron Court			26009			US.	A	
dear	ems ;	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)- 14. Ra	ce - Americ	
after 5	or its		1 Never Married 2 Married	1 ☐ Yes 2√∑ No If Yes, Give		1 □ Yes 2√⊑ No	Specify:	, , , , , , , , ,	Specia		
OOSO hours af	tural" al Ex	d by	3℃ Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of E	AATIT	
. 72 ni	ר" ה ledic	olete	(Specify only highest grad	de completed)	(Give	kind of work done	during most of work d)	ing	TOD. TRING OF E	003111633/1110	uusti y
with A	r thai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Bear	utician			Cosm	etolo	gV
ING ZIZIS-UUSO be filed within 72 hours after death with the Maryland tal Hydiene.	othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle			
aryiar should b	iten 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	William Spring				Nellie :	Butler			
2 shc	is m		19a. Informant's Name/Relationship (7	ype. Print)			and Number or Rui			, State, Zip	Code)
c, s l and lealth	m 27 her t	- 5	Linda Kreh Da 20a. Method of Disposition	ughter	2906	Byron Co	ourt Abin	gdon, M	D 26009 20c. Location	City or To	Duran Chaka
ages of the	or of		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of natory or other plac	1			-	
DAILLIMO Dermit. Pages Department of	rtant njury		4 Donation 5 Other (Specify 21. Signature of Funéral S	14.4	ount Oli	vet Cem.	12/8	3/2007	Frederi	ck, M	Maryland
	Important: If item 27 is any injury or other tra			MO11	176 10	06 East C	ss of Facility Kee Church Sti	eney a . reet Fr	basioro ederick	MD '	г.н. 217∩1
- w	. P#		23a. Part. Enter the disease, or comp							,	Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	a. Arteriosc						1	Onset and Death Years
/M	edical		resulting in death)	Due to (or as a con		Cardiova	SCUIAL DI	LSEASE			Tears
Exa	iminer	74	Sequentially list conditions,	b							
\ B	ısıt	Examiner	Sequentially list conditions, if any, leading to humboliate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or the sinon	raedrieure or);						
Xecui	al-trar	xan	that initiated events resulting in death) Last	cDue to (or as a con	sequence of):						
The law requires that the death certificate be executed	physician and s the burial-transit	Sal		d							
tificate	ig phy as the	ledical		· u.							
th cer	endin r use	N/ue	230. Was decedent pregnant	23c. If yes, outcome pf pro		Ectopic pregnancy	,			ate of delive	
e dea	been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No	4□Pregnant at time 9□Unknown		Other (specify)	<u>'</u>		M	onth	Day Year
r at the	d by t etach	Phy	9 ☐ Unknown Part II. Other significant conditions or	patributing to doubt but not	reculting in the u	adorlying source give	on in Port I	23a Did	tohanno uso non	stributa ta th	he cause of death?
ires t	signe I be d	by	artii. Other signmeant conditions of	orthodolog to death out not	resulting in the di	indenying cause giv	en arracti.		Yes 2 No		
w requires	peen	etec			-,, -, -			821	54.3		
he lay	ge 2	Completed						24a. Was auto perfe		prior to col death?	psy findings available mpletion of cause of
	certificate rector, pag		25. Was case referred to medical				26. Place of Deat	1 Yes		1 ☐ Yes	2□No
ysicia	s cert direct	o Be	examiner? 1 🕱 Yes 2 🗌 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or.		dence 6 □Ot	her (Specif	(v)
5 £	ter this neral dir	in T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injur Wor			how injury occu		<i></i>
Attending r death.	or: At	atic	2 ☐ Accident investigation				Yes 2 □ No				
or Att	lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Sp.	At home, farm, str pec <i>ify)</i>	eet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Number,
pital o	eral C		200 Cortifier 1 Certifying Ph	veician: To the best of my	knowledge deet	h occurred at the ti	mo data and place	and due to the	coupe(s) and m	200001000	totad
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		ysician: To the best of my liner: On the basis of examand manner stated.							
To the	To the	Me	29b. Signature and title of certifier	0.		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
			1 alan H	Holisen 1	(DDM)	≡ D3	7197		Decembe	er 5,	2007
			30. Name and address of person who of Alan H. Rohrer, M	completed cause of death	(Item 23a) (Type,	Print)	C1 :	E 1	1 14	-	1 04704 /50
	17					Seventh	Street,	rreder	ick, Mar	yLanc	1 21/01-450
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's S	ignature 408	de?					

State of Maryland / Department of Health and Mental Hygien [9] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBERDO , 2007 12:15 AM **Physician** MARY ELIZABETH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, July 2, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Pennsylvania 1 M 2 XF 84 295-14-7327 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 10a. State X□Yes 2□No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or ; r must be r 21703 U.S.A. 593 Cawley Drive, Unit 1A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the M Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Secretary permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Collins Edward Hulbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 593 Cawley Dr., Unit 1A, Frederick, MD 21703 Mr. Edward R. Smith, husband Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park Dec. 7, 2007 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State N. Olmsted, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee Reeney and Bastord PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 2 No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate has autopsy pentension perform 2 N No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation death. 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064910 Jandey, M.D. 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) 10 m.D. 400 West Seventh St., Frederick, MD 21701

State

Registrar

31. Date filed (Month, Day, Year) DEC 1 1 2007

07-09220	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene									
	1- For State Registrar	State of I	viaryianu /		ite of Deatl			20 (39709	
Physician/ Medical Examiner		e (First, Middle,Last)	STI	RGILL			Date of Deat Month November	Day Year	3. Time of Death 1600 hrs	
(4a. Facility Name (if not institution, give street and number) 10417 Smitty Way #1 4b. City, Town, or Location of Death White Plains						4c. County of De Charles	ath		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign								eign	
Director	220-38-4830 1 M 2XX 65 Yrs. Molitilis Days Hours Mill. 04/06/1942 Country MARYLAND Usual Residence of Decedent									
w any	10a. State 10b. County 10c. City, To							10d. Inside City Limits 1 Yes 2 X XNo		
the Maryland a or 28a-f sho tified at once.	MD 10e. Street and Nu				PLAIN:		1	0g. Citizen of What C		
the Ma Sa or 28 otified a					0695		U. S.			
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Fleath and Mental Hygiene. Itant: If iten 27 is marked other than "natural", or items 33a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Marri		Was Decedent E Armed Forces?		13. Was Decede If Yes, specif	ent of Hispanic Origin? (S fy Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - An White, etc	nerican Indian, Black, 	
ufter der il", or i ner mu y Fu	3 Widowed	3 Widowed 4 Divorced or Dates:			1 Yes 2	No specify:		Specify: WHTTPE		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner To Be Completed by I		ducation (Specify only hi	ghest grade comp	,		Occupation (Give kind of rking life. DO NOT use ref		16b. Kind of Busine	รร์/เกิดน์รtry	
5-0036 ed within 72 hour officers than "natu the Medical Exan Completed	Elementary/Sec	ondary (0-12)	College (1-4 of 5	·	RTENDE	R		TAVERN		
21215-0036 uld be filed within 7 Mental Hygiene. evert, the Media	17. Father's Name	(First, Middle, Last)					•	Maiden Surname)		
2121: ould be fil ould be fil	and the second s	W C. BUCKI ame/Relationship (Type,		191	. Mailing Address	Street and Number or	NCE E . Rural Route Nur	ROBEY nber, City or Town, S	ate, Zip Code)	
and 2 sho lealth and tem 27 is traumati		. STURGILI	L JR./S	ON 1	1955 AI	MY DRIVE I	A PLAT	A. MD 20	646	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Fleath and Mental Hygiene Important: If item 27 is marked other timpury or other traumatic event, the Med To Be Com	20a. Method of Dis	Cremation 3 F	Removal from Sta	te cremate	ory or other place)				
altim nit. Pa Nartmen Sortant ny or c	4 Donation 5 Other Specify: W.ARUNDEL CREMATORY 12/3/07 ODENTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A.									
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Physician /Medical	failure. List or	nly one cause on each li				or dying, such as cardiac	or respiratory arr	est, shock, of hear	Between Onset and Death	
xaminer	Immediate Cause or condition result		to (or as a conse		., 01 10100					
ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):									
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68760, certificate be nding physici as the buritani Med	IF FEMALE: 23b. Was deceden	t pregnant in the	3c. If yes, outcom	ne of pregnancy	Fetal death	3 Ectopic pregr	nancy	23d. Date of deli Month	very Day Year	
	past 12 month 1 Yes 2	4		time of death	Other (Spe	ecify)				
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Records, The law requires ficate has been sig							auto	24a. Was an 24b. Were autopsy findings available prior to completion of cause of		
Recc The lav icate ha							1 ✔ Yes	ormed? deat 2 No 1	h? Yes 2 No	
Vital Recystian: The his certificate director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other: Scene									
n of Virding Physical	1 Yes 27. Manner of Dea 1 Natural	2 Noath5 Pending	28a. Date of Inju FOUND: Day,Y	n/ 28h	Time of Injury JND:	28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe Subject sho	how injury occurred ot self		
Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the him 24 hours after death. The Funeral Director: After this certificate has been signed by applicitly filled in by the funeral director, page 2 should be detach lical Certification: To Be Completed by P	2 Accident Investigation Investigation Nov 28, 2007 1600 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 10417 Smitty Way #1 White Plains, MD									
Di To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the He within 24 To the Fu To the Fu completel	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date s							(Month, Day, Year)		
	1	cushe y	er i	7 ms O.C.M.E.			November 29, 2007			
\	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar	31. Date filed (Mo	-	100		Jarle					

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of IV	C	ertificate of			eg. No.	1	37111	
Physician			Decedent's Name (First, Midd		2. Date of Death Month				3. Time of Death			
/Medical			MARGARET DOLOR		NOVEMBER			2007	1:15P M			
Examiner			4a. Facility Name (If not institution		4b. City, Town, or Location of Death CLINTON			of Death	ODCEC			
			BRADFORD OAKS 5. Social Security Number		REHAD ge (In yrs. last birthd			8. Date of Birth			EORGES lace (State or Foreign	
	Funeral Director		466 56 8774	1 □ M 2/□XF	68 Yrs	Months Davs		8. Date of Birth (Month, Day, JAN. 20,	1939	Coun TEXA	try)	
e, Maryialla ZIZI3-0030 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. am 27 is marked other than "natural", or Itams 23s other traumatic avant, the Madical Examble in the		Usual Residence of Decedent 10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c. City, Town or	Location				1	Od. Inside City Limits		
	P	MD PRINCE GEORGES FORESTVILLE								XXYes 2 □ No		
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	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 1	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-		e - Americ			
	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed XX ☐ Divorce	rried 1 ☐ Yes XX	1 ☐ Yes XX No		1 ☐ Yes XXX No Specify:			Specify: BLACK			
	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. De	cedent's Usual Occu	king	16b. Kind of B	6b. Kind of Business/Industry				
	d m	Elementary/Secondary (0-12)	5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
		12TH 17. Father's Name (First, Middle	(act)	C	LAIMS ADJI		e (First, Middle, N	PRIV				
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	L P	JAOHN PAUL HER			ailing Address (Stree				State, Zip	Code)		
		AIMEE C. JACKS	ON / DAUGHTE		4 HILMAR (EVILLE,				
		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla			20c. Location -				
		XX Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (*	MEMORIAL	I I	4/2007	SUITL	AND.	MD		
Dallillo	Departr Imports any inju		21. Signature of Puneral Service	Licensee		22. Name and Addr MARSHALL 3 4308 SUITI	ess of Facility S FUNERAL	HOME OF			INC.	
1	8		23a. Part . Enter the disease, o	r complications that cause	d the death. Do not					0740	Approximate Interval Between	
Physician /Medical Examiner		Immediate Cause (Final disease or condition	t only one cause on each	a,					Onset and Death			
		resulting in death)	aDue to (or a									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
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orou,	physician and the burial-transit											
Tificat	ට දැ	Medi	LE SELVIS									
w requires that the death cert been signed by the attendin should be detached for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②▼▼No 9 □ Unknown	1 Live birth	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year			
s that	ned b	by Pr	Part II. Other significant condit	ions contributing to death	but not resulting in th	e underlying cause gi	erlying cause given in Part I. 23e. Did t			obacco use contribute to the cause of death?		
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a w	as be 2 sh	ple					24a. Was ar autopsy			psy findings available inpletion of cause of		
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	erti	4 Homicide determ	mined 286. Place of it building, e	building, etc. (Specify)			City or Town, State)					
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10.			Willia !	p3.	D35206			N Nember 16 2007				
,	B1	1	William T. TANKER US 11701 Livings In Rose Fort Washington un 2074y									
	- 4	Į)	William T.	TANNERY		Lidustr	Konst Fo	t wash	ingon	47	20/44	
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1.5	Registr	ar	~ 5 2007	Starein 10.	ppere							

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SHERMAN

SYLVAN

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sandra Delistatus 8600 01d Ge

8600 Old Georgetown Road, Bethesda, Maryland 20814

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BERTHA Μ. SMITH 12, NOV. 2007 10:24AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Casey House MONTGOMERY Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 15, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. Davs Hours 80 Maryland 201-22-6377 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Howard Woodbine ar than "natural", or items 23a or 28a-f should must be notified 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 15202 Bushey Park Road 21797 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or itel 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County College (1-4or 5+) Elementary/Secondary (0-12) 12th Bldg. Service Worker Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfield Parker, Sr Margaret V. Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 st of Health ar 15202 Bushey Park Rd., Woodbine, MD 21797 Joseph Smith (Husband) Department of Healt Important: If Item 2 any injury or other once. Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 11/15/07 Parker Cemetery Cookesville,MD 4 Dopation 5 Other (Specify) of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signa 246 N. Washington St, Rockville, MD 20850 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or higher failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Renal Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 XNo 2□ No 1 TYes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sther (Specify) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, of or Attending Fatter death. To the Hospital within 24 hours at To the Funeral C

Saltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/12/07 (m) D0064615

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Génevieve Wroblewski, M.D. 6001 Muncaster Mill Rd, Rockville, MD 20850

Registrar

31. Date filed (Month, Day, Year) NOV 2 7 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Kosa, Shor (OPM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner olliv Via Habran If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) 03/11/1914 9. Birthplace State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖫 F 93 POLÁND Director 093-16-8289 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 No Director MARYLAND MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 610 STILL CREEK LANE 20878 U.S.A. "natural", or items 23a dical Examiner must t Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2K No Specify ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental HERSCH VOGEL MARION TERNER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health MARION R. ROTHCHILD, DAUGHTER 610 STILL CREEK LANE, GAITHERSBURG, MARYLAND 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 Removal from State MT. ZION CEMETERY 11/26/2007 4 □ Donation 5 □ Other (Specify) MASPETH, NEW YORK 21. Signature of Functal Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. acou Cur 20852 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Premari 3 mays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: Se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ➡ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No som an 2E No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending Iniury

Division or Vital Records, P.O. Box 68760. After this Hospital or Attending 24 hours after death.

funeral director. filled in by

2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier DUNERD 29c. License number D0057884 29d. Date signed (Month, Day, Year) 257

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar

Medical



within 2. To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOV. 21 pay 200°7 LOU SCOTT 10:04 AM **DEBRA** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital MONTGOMERY Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 26, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 56 Illinois 516-62-5538 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Examiner must be notified at MD Montgomery Rockville 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 20852 11333 Schuylkill Road U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc within 72 hours after 1 Yes Mo If Yes, Give Year or Dates: Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed wit.

I Hygiene.

I than " Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 8th h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron Sarks Louise Jackson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11333 Schuylkill Road, Rockville, MD 20852 Deanna Hinkle (Daughter) item 27 Place of Disposition (Name of Semetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☐ Bynal 2 ☐ Cremation 3 ☐ Removal from State Ri Riverdale, MD 4 □ Donation 5 □ Other (Specify) erdale Pk Crem 11/24/07 21. Sign of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to in modals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trans 7 Due to (or as a consequence of): 68760 7-eny dispass Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown signed by the aid 5 Other (specify) 1 ☐ Yes 2176 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No or Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 LER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F after death. I Director: After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier

State

Registrar

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16 31. Date filed (Month, Day, Year) NOV 2 7 2007

SWAN Registrar's Signature

50. Name and address of person who completed cause of death (Item 232(Type, Print) $8\,600\,$ Old Georgetown Road; Bethesda, MD 20814:

7188

State Registrar

31. Date filed (Month, Day, Year)

2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Dav Year Physician Month 12:47 A M Slacum heresa Wynet 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Navyland Nedical
5. Social Security Number | 6. Sex | 7 Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗹 F 212-66-130 Decedent 5 2 Director July 28,1955 Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural" or Items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No Dorchester Director MD10f. Zip de 10e. Street and Number 10g. Citizen of What Country? Road-Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "natural" or Item
any Injury or other traumatic event, the Medical Examiner
once. Black, White, etc. Pages 1 and 2 should be filed with in 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify þ 3 ☐ Widowed 4 1 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood Helper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Slacum 2 Powell Helen 19a. Informant's Name/Relationship (Type. Print) Daughte K 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . apt. 208 Cambr. dge. / Date 20c. Location - City or Town, State Hudson Rd TereKa 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Market Cemetery 12/107 E. New Market, MD.

22. Name and Address of Facility
Henry Funeral Home, R.A.

5 10 Washington St. Cambridge, MD. 2/6/13

Approximate 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemorrhage intracranial 28 hrs /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1261107 26 07 SURGICAL RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar RASHUDA JETTKION

31. Date filed (Month, Day, Year) NOV 2 8

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GREENE

Registrar's Signature

BALTIMORE MO 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3,211M Hurley Short /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico bastal d If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Aug. 4, 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1913 1 M 2 S F Months Days Hours Maryland 215-36-2049 94 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Yes 2 No Director Dorchester Cambridge filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 424 Aurora Street 21613 LISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21K No Specify. Completed by white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 11 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental Hi tant; If item 27 is marked oth Be James Daniel Hurley Ruth Davidson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Creekside Dr., Salisbury, MD Ramona Dempster daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any Injury or ot 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 11/23/07 4 ☐ Donation 5 ☐ Other (Specify) East New Market, MD permit. 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNRUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCT | UR PULMONARY DRSPASE HRONIC sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the hiria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No cate has t 1∐ Yes in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA s after death. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CHULAM WARIS

31. Date filed (Month, Day, Year)

COASTAL

DHMH 17 Rev 1/2001

PU BOX 1733 SALISBURY W 21802

2

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 29a. Certifier (Check only

one)

30. Name and

29b. Signature and title of certifier

31. Date filed (Month, Day

address of person who completed tos Dita

NOV 2 7 2007

and manner stated.

1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Funeral Director

	laryland / Depa			lental Hygier	ne						
1 - State Registrar	Cei	rtificate of	Death	Reg. I	000 COV	2072					
1. Decedent's Name (First, Middle, Last)				Date of Death Month	Z U U	8 Time of Death	1				
Alfred Leon Stern				November			1				
4a. Facility Name (If not institution, give street and number 3158 Gracefield Road #308	-)	Silver S	Location of Death		4c. County of lontgon						
ATT OF F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	17)	Birthplace (State or Foreign Country)	ın				
Usual Residence of Decedent	79 Yrs.			July 8, 1	928 1	New York					
10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	3				
MD Montgomery	Silver Sp	ring				1 □Yes 2 X No	Э				
10e, Street and Number		10f. Zip Code		10g. (Citizen of Wh	at Country?					
3158 Gracefield Road #308		20904		USA							
11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼	?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.					
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates		1 □ Yes 2 X No	Specify:		Specify:	White					
15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	16b.	Kind of Busi	iness/Industry					
Elementary/Secondary (0-12) College (1-4or	5+)		during most of work i)		_						
17. Father's Name (First, Middle, Last)	Profe	ssor	10 Mathada Nasa	Hi e (First, Middle, Maid		Education	_				
Harry Stern				e (<i>First, Middie, Maid</i> aubenhouse	,						
19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street		ral Route Number, Cit		tate, Zip Code)					
Anne Peskin/sister		hornridge		Stamford,							
20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	ce)	Date 20c.	Location - C	ity or Town, State					
4 □ Donation 5 □ Other (Specify)	Chesapeak			· I	tsvill	•					
21. Signature of Funeral Service Licensee	Ğ	2. Name and Addre oing Home	ss of Facility Cremati	on Service	P.O.	Box 784					
MO1251 Beverly I. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the wease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
23a. Part1. Enter the twease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death											
Immediate Cause (Final disease or condition resulting in death) a. Transfusion induced HIV disease Due to (or as a consequence of):											
· ·	s a consequence on.										
Sequentially list conditions, if any, leading to immediate b. Due to (or a	s a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
resulting in death) Last Due to (or a	s a consequence of):										
d											
IF FEMALE: 23c. If yes, outcom	e pf pregnancy				23d. Date	of delivery					
in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (spec <i>ify)</i>	<u>'</u>		Mont	•					
9 ☐ Unknown 9 ☐ Unknown											
Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contrib	oute to the cause of death?					
Chronic Renal Failure				1 ☐ Yes	2 No 3	I Probably 4 ☐Unknowr	n				
				24a. Was an autopsy	i nri	ere autopsy findings available or to completion of cause of	е				
				performed′ 1∐ Yes 2X	P de No 1 E	ath? ∃Yes 2⊟No					
25. Was case referred to medical examiner? Hospital: Hospital:		Out	or:	h (Check only one)			_				
1 ☐ Yes 2 X No 1 ☐ Inpat 27. Manner of Death 28a. Date of In			TE Italishing Fit	ome 5 XResidence		(-1)/					
1 Natural 5 □ Pending (Month, D	ay Year) 200. Thise of	Wor	yat k? Yes 2 □ No	28d. Describe how in	jury occurred	1					
3 Suicide 6 Could not be determined 28e. Place of in	l njury - At home, farm, str		.00 2	28f. Location (Street	and Number	or Rural Route Number,	_				
4 ☐ Homicide determined building, €	etc. (Specify)			City or Town, Sta	ate)						
29a. Certifier (Check only one) Check only one) Check only one) Medical Examiner: On the basis and magners	of examination and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and man and place, an	ner as stated. Indidue to the cause(s)					
29b. Signature and title of certifier		29c. Licens		29d. I	Date signed ((Month, Day, Year)					
I granare Widle		1006	4615	11/	21/20	007					
30. Name and address of person who completed cause of				- /	/						
Genevieve Wroblewski, M.D.		rd Drive	Rockvill	e, MD 2085	0						
	trar's Signature	(w									
	was so for	ロスペイン									

DHMH 17 Rev 1/2001

State Registrar

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State of Maryland / Department of Health and Mental Hygiene U	land / Department of Health and Mental Hygien 🛭 🛭 🧻
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			1 - For State Registrar	State of Ma		Departmen Certificate				giene UU	1 3	9122
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physici /Medic		ROBERT	LEON	SEA	7 IV			NOVEME	Ex 24 2	007 T	23,54PM
	Examin		4a. Facility Name (If not institution, give					or Location of Death		4c. County of		
			HANFORD METER	oute Ho	SPITAL	HAL	IRE	05 GRA	CE	HAR		
	Funeral Director		5. Social Security Number 6. Sex 217-40-9441	M 2□F	(In yrs. last bin	Yrs. If Under Months	1 Year Days	Hours Min.	8. Date of Birt (Month, Day May 1,	h y, Year) 1943). Birthplace Country) Ma	e (State or Foreign ryland
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d	Inside City Limits
	Manyla I eho	ō	Maryland Cec			lora						1 □Yes 2 XNo
	28a-	rect	10e. Street and Number	11		10f. Zip	Code			10g. Citizen of Wh	nat Country	?
	death with the Maryland ms 23a or 28a-f ehow must be notified at	Ī	839 Colora Road				219	917		USA		
	death ms 2	nera		12. Was Decedent Ev	ver in U.S.	13. Was Deced		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		- American	
7 9	n 72 hours after death with the Marylan "natural", or Items 23s or 28s-1 show sides! Examinar must be mutified at	by Funeral Director	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		1 Yes, spec			Hican, etc.)	Specify:	White, etc.	
35	hours after tural; or its	d b	3 Widowed 4 Divorced	Year or Dates:							White	
215-0036	be filed within 72 hours a al Hygiene. I other than "natural", o went, I a Medical Exam	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Decedent's Usua (Give kind of wor	l Occup	pation during most of work d)	ing	16b. Kind of Busi	ness/Indus	try
212	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	omputer '				Ran	king	
	filed Hygi other		17. Father's Name (First, Middle, Last)	4	00	mputer	Teci		e (First, Middle,	Maiden Sumame)		
0 lan	lid be lental rked tic ev	To Be	Robert L. Seay III					Helen	McMille	en		
A 4 10 7 Maryland	shou and N		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	Mailing Address	(Street	and Number or Rui	al Route Numbe	er, City or Town, St	tate, Zip Co	de)
	ies 1 and 2 should be filed within of Health and Mental Hygiene. If Item 27 ie marked other than "I other traumatic event, I a Marke		Christine M. Seay/	Wife				ra Road, (
ore	Pages 1 nent of H int: if iter iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	20b. Place of cemeter	Disposition (Nam y, crematory or o	ne of ther pla		Date	20c. Location - C	ity or Town,	, State
Baltimore,	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		West 1			Cem. 11-		Colora,	Mary	land
Ba	permit. Pages 1 and 2 Depertment of Health s important: if Item 27 li any Injury or other tra		21. Signature of Funeral Service Licens	_		22. Name an R. T. 111 S.	Addre Foai Que	ess of Facility rd Funera: een Street	l Home, t, Risin	P.A. ng Sun, M	D 219	11
			23a Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused to e cause on each line	he death. Do r	not enter the mod	e of dyn	ng, such as cardiac	or respiratory ar	rest,	Int	proximate terval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)					7 CANCI				nset and Death MONTH
	/Medical Examiner		resulting in death)	Due to (or as a								
		_	Sequentially list conditions,). Due lo (or as a	CHICAGO	N.						
25	nted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	555 15 (5: 252	001.004201.00							
· ·	icate be executed physicien and s the burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequence	of):					_	
68760,	te be ysicie ne bur	edicai		i								
_	certifica nding ph use as th		IF FEMALE:									
Box	death ce e attendii ad for use	an/h	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death	3 ☐Ectopic pr	egnanc	y		23d. Date Month		y Year
0.E	he death certific: the attending pt ched for use as t	Physician/M	1 Yes 2 No	4□Pregnant at ti 9□Unknown	me of death	5 Other (sp	ecify) _			WON	ı Da	y 1621
· O D	that the set by detac	F.	Part II. Other significant conditions con	ntributing to death but	not resulting in	the underlying c	ause on	ven in Part I.	23e. Did to	obacco use contrib	oute to the c	ause of death?
rt Leon of Vital Records,	w requires that the de been signed by the a should be detached f	ted by	PENFORATED AR	_		, ,	-			Yes 2 □ No 3	4.	
PON Recor	aw 2 st	Completed		ATOLY IN	suppl	CIENCY	, (CHRONIC		an 24b. We pri	ere autopsy or to compl ath?	findings available etion of cause of
7	n: Th licete rr. pag		LING BISEASE						1 ☐ Yes	250 No 1		No
₹	sicia certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	t 2 ER/Ou	tpatient 3□ DC	Ott	26. Place of Deat			(0 (1)	
7	y Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day			Bc. Injui			now injury occurred		
be	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear) II	njury M		rk? Yes 2 □No				
Rober	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director; page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	rm, street, factory	, office		28f. Location (S City or Tow	Street and Number vn. State)	or Rural Ri	oute Number,
	pitei qurs al		200 Contition 17% Continue Phys	siaian. T. sha ha sa sa	months and a day	4						
	24 ho Fun	Medical	29a. Certifier 1 Certifying Physical Control 2 Medical Examination one)	sician: To the best of ner: On the basis of e and manner state	examination an	ovor investigation,	in my o	me, date and place, opinion, death occur	red at the time,	cause(s) and manr date and place, an	d due to the	e cause(s)
	within To the	Me	29b. Signature and title of certifier		-	290	. Licens	se number		29d. Date signed (Month, Day	v, Year)
			Ve A	- na	,	0	2	1338	^	NOVUTUER	_ 26	. 2007
_		1	30. Name and odress of person who co									
	6		ALAN SWEATTHA	1 HAROM	U ME.	roeiac	He	spirate,	HAURI	TDEGA	400	100
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 7 2	32. Registrar	s Signature	Book		SPITAL				

DHMH 17 Rev 1/2001

45EE COLHE 111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 2007 Stinebaugh November 22, Nettie Lee /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 133 Lakeview Drive Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 TF 220-26-7756 77 Director 7/26/1930 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or itams 23a or 28a-f shov other traumalic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Lakeview Drive 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: þ white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) at Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) co/owner/operator electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Nental Hint: If item 27 is marked or John Griffith Lola Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Lakeview Dr., Salisbury, MD 21804 John C. Stinebaugh/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit, Pages
Department of It
Important: If ite
any in|ury or of 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Union Church Cemetery 11/27/07 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licensee Domoson CESP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple te Isma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed tran that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 Yes 2 No certificate 2 No Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manger of Death 28b. Time of 28d. Describe how injury occurred or Attanding 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 00 66 198 26 6 30. Name and tolder of person who completed cause of death (Item 23a) (Type, Print) 145 E. Carroll St., Salisbury, MD 21801 Dr. Joseph Grasso

State Registrar 31. Date filed (MNID Pa)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	1arylan		rtment of F	lealth and N Death		giene, Reg. No.	2007	39724
			Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath		3. Time of Death
	Physici /Medio		Vernon Selby, Sr.						Month Nov.	Day 23	Year 2007	0200 M
	Examir		4a. Facility Name (If not institution, gi	ve street and number	r)		4b. City, Town, o	or Location of Death			County of Death	
			Atlantic General	Hospital			Berlin			V	Worceste	
	Funeral			Sex 7. A 1 1 1	ige (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)		place (State or Foreign ntry)
	Director		217-28-4317 Usual Residence of Decedent		85	Yrs.			March_	2, 20	07 Ma	ryland
	land •••		10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Man Freh	ģ	Marvland Worcest	er	l p	Berlin						1 ☐ Yes 2 🙀 No
	or 28	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	23a	a	10349 Harrison Ro	oad			218	11		U	SA	
	er des	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Americ Black, White, 	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates		1	☐ Yes 21 No	Specify:			Specify: Blac	1-
Ş	within 72 hours after death with the Maryland ane Then "neturel", or Items 23a or 28s-f ehow he Medical Examinar must be notitied at	Pe	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	pation		16b, Kir	nd of Business/In	
215	hin 72	Completed	(Specify only highest gi	ade completed) College (1-4or	(5+)	(Give	kind of work done O NOT use retired	during most of work	ang			
21	ed wit giene er the	EOC	7th		0.,	labore	er- self-e	employed		Lan	dscaping	
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle	, Maiden :	Sumame)	
<u>8</u>	Men	2	Henry Brittingham					Katie				
Marvland 21215-0036	12 sh h and 7 te m rreum		19a. Informant's Name/Relationship					and Number or Rui				
	1 and Health em 2 ther t	1 3	Jesse Turner/nephe 20a. Method of Disposition	W	20b. PI		Harrison	Road - I	Berlin, N		and 218 cation - City or To	
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages the pages should be filed within 72 hours after death with the Mantal Hygiene. Important: if Item 27 is marked other then "neturel; or Items 23a or 28s-f show eny injury or other treumatic event, the Medical Examinar must be notified at 90cs.		1 ☑ Burial 2 ☐ Cremation 3 [e C6	emetery, cren	atory or other place				,	
=	nit. Pertme ortan injur.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Car			ss of Facility 121				
ñ	Depermine Depermine Important Important Incorporation Inco		Patricial	2 Jalle	41			EMORIAL		-		21801
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	ed he death							Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition	One Gauss	lensi	last		A POSLECIE			3C. >-	Onset and Death
	/Medical		resulting in death)	a Due to (or a	s a consequ	ence of):	C -000	NY COLECTE	100			(Cere
0	Examiner	L	Sequentially list conditions, if any, leading to immediate	b								
20	ed Isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ence of):						
0	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequ	ence of):					1	
To D.:	cate be executed physicien and the burial-transit	dical		d								
2 89		edic	100	<u> </u>								
No X	eath certif attending for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom- 1 ☐ Live birth			Ectopic pregnancy	,		2	3d. Date of delive	,
23, E	Q 0 Q	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)				Month	Day Year
W. Z.	The law requires that the sie hes been signed by the page 2 should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions		but not room	Ning in the	d- 1 (an in Oant	Jan Did A	<u></u>		he cause of death?
POB POD: ords,			Preum	•	DUL HOL 1950	iling in the un	denying cause giv	en in Pan I.		obacco us Yes 2□		pably 4 Munknown
79 9	w requir been si should	ete							24a. Was			
ເກດກ ກວຍ ກວກ Vital Records	he tav e hes	Completed					· • • •		auto		prior to co death?	ppsy findings available impletion of cause of
کور tal	sician: The t certificate he rector, page	0	25. Was case referred to medical	ľ				26. Place of Deat		2021No	1 🗆 Yes	2□ No
Vernon of Vital F	A	9 9	examiner?	Hospital:	ient 2 🗆 E	ER/Outpatient	3□ DOA Oth				i □Other (Specif	(v)
_	ding Ph h. After th funeral	Ju: T	27. Manner of □eath 1 □Natural 5 □ Pending	28a. Date of Inj (Month, D	ury av Year)	28b. Time of Injury	28c. Injun	y at	28d. Describe			,,
5. <u>Sioi</u>	uttending death. ctor: After / the fune	atic	2 ☐ Accident investigation	n		,,		Yes 2 □ No				
SR 4317 Bivision	lor Att after d Direct I in by t	Certification:	3 Suicide 6 Could not to determined	286. Place of it	njury - At horetc. (Specify,	me, farm, stre	et, factory, office		28f. Location (: City or To	Street and wn, State)	d Number or Rura	al Route Number,
28/2	Hospital 24 hours a Funeral C		29a. Certifier Lertitying P	hveisian. T. th. b	A - 6 t	J-4 1 1					<u> </u>	
Selby 17-2		Medical	(Check only one)	hysician: To the bes miner: On the basis and manner s	of examinati	on and/or inv	estigation, in my o	pinion, death occur	red at the time,	date and	and manner as s place, and due to	tated. o the cause(s)
25ch	within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	145		MAM	Mr	2	>	D2	8769	7	10	12360	.7
	280		30. Name and address of person who	completed cause of	death (Item	23a) (Type, F	Print)	1 11		-	100	
-			Wellder Baros	believe,	a.	(207	Ceresto	d Itesh	un to	euc	toloko	JNE 19944
	Sta Registr		31. Date filed (Month Day, Year) 2	007 32. egist	trar's Signat	ure /	a.H.					*
		W. 1		7-10-01	1	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	Marylan		artmen <i>rtificat</i>					Reg. No.	007	39725
	Physici /Medi		Decedent's Name (First, Middle, L BARBARA ELIZ	ABETH TU						I	2. Date of De Month DECEME	BER 1	2007	3. Time of Death 9:25a M
	Examir	ner	4a. Facility Name (If not institution, g Chestertown N	ursing &	Reha		Che	este	rtow	n ,		Ken		
l.	Funeral Director		5. Social Security Number 6. 215-20-0768 Usual Residence of Decedent	Sex 7.7 1 ☐ M 2 🔀 F	90	/ast birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min	8. Date of Bin (Month, Da Mar 9	1917	9. Birth Cou Mar	place (State or Foreign Intry) yland
	me 23a or 28a-f ehow	tor	10a. State 10b. County MD Kent			y, Town or Lo alena	cation							10d. Inside City Limits 1 ☑Yes 2 ☐ No
1000	23a or 28a	ai Director	10e. Street and Number 113 South Mai	n St.			10f. Zip	Code 1635				10g. Citizen o		untry?
0500-0	neturel, or iteme	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? <u>a</u> No		Was Deced f Yes, spec 1 Yes		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto P	cify Yes or No Rican, etc.)	14. F E Spe	lace - Amer lack, White cify: W	
0-CIZIZ	perim. Teges I and a Stoom be filed within 72 hours after beath with the watyfel periment of Health and Mental Hygiene. Important: if I lem 27 is marked other then "neturel; or Iteme 28a or 28a-f ehow eny injury or other treumatic event, its Medical Examinar must be notified at ance.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		r 5+)		lent's Usua kind of wo DO NOT us nemak	rk done d se retired)	ition u <i>ring m</i> ost	of workin	g	16b. Kind of	Business/l	ndustry
ıryıand	Health a should be med within the that A is marked other then ", ther treumatic event, the Max	To Be (John Batchelo: 19a. Informant's Name/Relationship	r		19b. Mailir	ng Address		Mur	iel	Elbou	Maiden Surr rn er, City or Tov		ip Code)
	or other treu		Martin Holden 20a. Method of Disposition 1 XBurial 2 Cremation 3	(grand	20b. P	317 lace of Dispo	Trus	slow ne of ther place	Rd.	Che	estert	OWN ,	MD n - City or T	21620 Own, State
Daltimor	Departmen Important eny injury		4 □ Donation 5 □ Other (Special Service Lice	aceas ()	Ga M0051	lena Ga 0 11			_ ,	12/5 l Hc s St			na, I	MD. L. Schaech 21635
	nysician /Medical		23a. Part1, Enter the disease, or construct, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	mplications that caus y one cause on each a. Due to (or	otur	Do not ent	er the mod	e of dying	, such as	cardiac or ∧	PUPIS	rrest,		Approximate Interval Between Onset and Death
	xaminer end the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a										
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Tuice that	n signed build be deta	Ď	Part II. Other significant conditions	contributing to death	but not resu	alting in the ur	nderlying c	ause give	n in Part I.			obacco use co		the cause of death?
The law on	r this certificete hes bee	Completed	Dement	19							24a. Was autor perfo	rmed?	b. Were aut prior to c death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
V 1C	s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2	ER/Outpatien	. 2 D D	Othe	- 4		Check only o	nnel dence 6 ⊡0	Nahaa (Cass	Z.1
odino Ph	within 24 hours after deeth. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	11-17	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		8c. Injury Work		21		now injury occ	, ,	ny)
ital or Atta	within 24 hours efter deeth. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determined	building,	etc. (Specify	·)					City or Tov	vn, State)		ral Route Number,
the Hoen	hin 24 hou the Fune npletely fil	Medical	one) 2 Medical Exa	hysician: To the besiminer: On the basis and manner s	of examinat	wledge, death ion and/or inv	restigation	, in my op	inion, deatl	d place, au h occurre	d at the time,	date and plac	e, and due	to the cause(s)
Ţ	To		29b. Signature and title of confifier	ul			290	License	2 C	F 2	4	29d. Date sig	o Z	, Day, Year)
	4		30. Name and address of person who Paul Donaher,					in S	t. G	ale	na. Mr	216	35	
	Sta Registr		31. Date filed (Month Pay Credy) 1	2007 32. Regis	trar's Signat	A A	carle)	-		,			

DHMH 17 Rev 1/2001

IVa

Registrar

State

5

14300 Gallant Fox

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora

NOV 2 7 2007

31. Date filed (Month, Day, Year)

ORIGINAL

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Suito ZZZ

BOWIE, MD. 2015

director, this After

Physician: or Attending after death filled in by the thin 24 hours a

Be

Certification: To

Medical

30. Name and address of person who

Dr. Karl Eric DeJonge

21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔽 Naturai Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 16, 2007

Registrar DHMH 17 Rev 1/2001

State

within 7

6

13)

Washington, DC

20010

110 Irving Street NW

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certificate of Death

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

MD 20901

Approximate Interval Between Onset and Death

Chronic

Texas

200

Montgomery

Black, White, etc.

Research/NIST

Specify.White

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Physician

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2₺ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

State

Registrar

one)

29b. Signature and title of certifier

John M. Wallmark, MD31. Date filed (Month, Day, Year) NOV 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Drive, #300, Rockville, MD 20850 egistrar's Signature

Mil.

DHMH 17 Rev 1/2001

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician November 23,2007 4c. County of Death AGNES VARIE SHORT TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wista ica La If Under 24 Hrs Hours Min. entek 8. Date of Birth (Month, Day, Year) APRIL 27, 1945 If Und 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 T Months Davs Min. MARYLAND 217-44-6637 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at r 28a-f sh notified 1 ☐ Yes 2 X No Director **CHARLES** INDIAN HEAD MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be r UNITED STATES 20640 6224 FORD DRIVE Funeral ural", or items 2 I Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygjene. ant: If Item 27 is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ 2121 Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be MARY JOSEPHINE (FENWICK) SHORT JAMES CLINTON SHORT, SR. altimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6224 FORD DRIVE, INDIAN HEAD, MARYLAND CHARLES RODNEY TAYLOR/ HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of MARYLAND VETERAN CEMETERY NOVEMBER 30, 2007 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 21. Signature of Funeral Service Sicensee LYDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

a

NOV 2

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Shvin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 25 2007 **Physician EMMA** THOMPSON MARIE 8:02 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛛 F 87 222-05-6775 Apr 16 1920 | Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 112 Collins St. Apt 6 21921 Funeral S . Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Black Specify. Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Someone else's home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Smith Ethel Pennick To 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Kelley (granddaughter) P.O. Box 292 Elk Mills, MD. 21920 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or important: If any Injury or Kent Cremation 11/28/07 Smyrna, DE. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Sign Fine of Fulleral Service Lyanson M00510 118 West Cross St. Galena, MD. 21635 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (rinal disease or condition resulting in design) **Physician** o (or as a consequence of): /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last trev Physician/Medical Examiner as a consequence of The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 📑 No Vital 1□ Yes Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) m) State Registrar

Pleas

e Type or Print in Black Indelible Ink. Ensure	All Copies Are Leg		
State of Maryland / Department of Health and	Mental Hygien	07	3973
Certificate of Death	Reg. No.		
Last)	2. Date of Death Month Day	Year	3. Time of Death

		Physici /Medic Examir	cal
	D	uneral irector	
2-0036	2 hours after death with the Maryland	latural', or itams 23a or 28a-f show ical Examinat must be rediffed at	ted by Funeral Director

Division of Vital Records, P.O. Box 68/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed A permit Pages 1 and 2 show	ther this certificate has been signed by the attending physician and metal director, page 2 should be detached for use as the buriat-transit	ar :a
Division of	To the Hospital or Attending Physics of Pours offer death	To the Funaral Director: After thi completely filled in by the funeral	

		1 - State Registrar			Certin	ficate of L	Death		Reg. No.).	•	
	8.	1. Decedent's Name (First, Middle, La	ast)					2. Date of De			Vasa	3. Time of De
nysicia Medic		Daniel Le	ee Thoma	s				Novemb	Day Der 2		Year 2007	2045
ieaic amin		4a. Facility Name (If not institution, given			4	b. City, Town, or	Location of Death			. County		2045
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1		218-48-8229	№ M 2□F	59	Yrs.	nonins Days	Hours Will.	11/11/			Mary	
		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	m or l oost	tion.					1	0d. Inside City I
,		Toa. State		Toc. City, 10v	wit of Locat	BOTI						1 ☐ Yes 2.
	ctc	MD Somerse	et	Princ	cess A							
	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of W	Vhat Coun	itry?
	ā	10665 Clarence H				218				US		
-	m	11. Marital Status	12. Was Deceden Armed Forces	?	13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-		e - Americ k, White,	
	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ If Yes, Give	No 1967-	1 🗆	Yes 2 No	Specify:			Specify:		
	g g		Year or Dates	17/7	Donodon	stin Linual Consum	tion		1ch V	and of Bu		ite
	ere	15. Decedent's E (Specify only highest gr	ade completed)	102	(Give kin	it's Usual Occupa ad of work done o NOT use retired	luring most of wor	rking	160. KI	ind of bu	isiness/Ind	ustry
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١	0	Arsby Lee Thomas	(Torre Dried)	140		Add (Ct	Mary Pa				Ot. 1	0-44
		19a. Informant's Name/Relationship				·	and Number or Ru					
		Maureen Thomas/W	11e			on (Name of	e Barnes	Road,			Anne City or To	
		1 ⊠Burial 2 ☐ Cremation 3 [comoto	ery, cremat	lory or other place	9)	Duito	200. L	JCation *1	City of 10	wii, State
		`4 □ Donation 5 □ Other (Speci		StP	eters	U.M. C	em. 11/	27/2007	Orio	ole,	Mary	land
		11. Signature of Funeral Service Lice	ensee		Hin	lame and Addres	s of Facility eral Hom	e				
-	_	Aneso WK	nas.	M00295	116	73 Some	rset Ave	Prin	cess	Ann	e, MI	21853
	/	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each	ed the death. Do line.	not enter t	the mode of dying	g, such as cardiac	or respiratory a	ırrest,			Approximate Interval Between
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-		resulting in death)	a	s a consequence	of):							
		Sequentially list conditions,	b									
	ner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence	of):							
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		resulting in death) Last	Due to (or a	s a consequence	of):							
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	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		ther (specify)			1	Mor	nth	Day Yea
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	by F	Part II. Other significant conditions			in the unde	orlying cause give	n in Part I.	23e. Did	tobacco u	use contr	ribute to th	e cause of dear
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	ပ်	25. Was case referred to medical					26. Place of Dea	1 Yes	2K No		☐Yes	2 No
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	-	27. Manner of Death	28a. Date of In (Month, D		Time of	28c. Injury Work		28d. Describe				//
	ō	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury		(? /es 2 ☐ No					
	72	3 ☐ Suicide 6 ☐ Could not b	De Diago of I	njury - At home, f	arm, street	t, factory, office		28f. Location	(Street an	nd Numbe	er or Rura	l Route Number
	ficati		building, e	etc. (Specity)		, ,		City or To	wn, State))		
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	dical Certificati	4 Homicide determined	hysician: To the bes miner: On the basis and manner s	of examination as	nd/or inves	stigation, in my op	oinion, death occu	ined at the time,	, auto uni	d place, a	and due to	the cause(s)
	Medical Certificati	4 Homicide determined 29a. Certifier Tertifying Paragraphic Check only 2 Medical Exa	miner: On the basis	of examination as	nd/or inves	29c. License		ired at the time,				Day, Year)
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DHMH 17 Rev 1/2001

			For State Registrar		(Certifica	te of	Death			Reg. N2 ()	07	39	732
Ħ	Physici	an	1. Decedent's Name (First, Middle,		Vessld				2	. Date of Dea	er 2, 2	∩ď 3 ar		of Death O AMM
2. 6.00	/Medic Examin	al	4a. Facility Name (If not institution,		Vaso1d			Location o		ecembe	4c. Coun	ty of Death)	- ATAM
- 1-	Funeral		7085 Cata1pa 5. Social Security Number 094-36-1784	6. Sex 7. Ag	e (In yrs. last birth		deri r 1 Year Days	CK If Under a Hours	24 Hrs. 8 Min. D	Date of Birt (Month, Pa	h	9. Birth	place (State	or Foreign
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	e Marylanda-fa-f show	ctor	Maryland Freder	ick	10c. City, Town Freder								10d. Inside 1 ∐Ye	City Limits
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 7085 Catalpa Roa	ad			p Code 1703				10g. Citizen o U.S.A	•		
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status XX Never Married 2☐ Marrie 3☐ Widowed 4☐ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ▼ If Yes, Give Year or Dates:		13. Was Dece If Yes, spo 1 ☐ Yes		ispanic Orig an, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	ВІ	ace - Ameri ack, White city: Whi		
Baltimore, Maryland 21215-0036	within 72 hou iene. 'than "natura the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or state)	(Decedent's Usi Give kind of w life. DO NOT t Clerk	ual Occup ork done use retired	ation during most f)	t of working		16b. Kind of	Business/Ir	ndustry	
land 2	ould be filed v Mental Hygie arked other t atic event, th	To Be Co	17. Father's Name (First, Middle, L Arthur Thomas	ast)						First, Middle, O'Conn	Maiden Surna	ame)		
Mary	and 2 should alth and Men 27 Is marke er traumatic		19a. Informant's Name/Relationshi Mrs. Rita M. Vas			Mailing Addres 085 Cat							p Code)	
imore	Pages 1 ament of He ant; If Item ury or other		20a. Method of Disposition f□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.		compton	Disposition (Na , crematory or Dlivet	other place	tery 1	Dec.		20c. Location 7 Free	•		·
Balt	permit. Page Department of Important; If any Injury of		21. Signature of Funeral Service L	Traf	MOO255						eral Ho erick,	me MD 21	.701	
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68760, 💝	rificate be executed as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of	u B	veu	nt c	Caru	Cen			MO	Mr
O. Box	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Moo 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3⊟Ectopic 5⊟ Other (s		/				Date of delivery	very Day	Year
ds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant condition	s contributing to death b	out not resulting in	the underlying	cause giv	en in Part I.	•	23e. Did to	obacco use co Yes 2 □ No			of death?
Division or Vital Records,		Completed								24a. Was autor perfo 1∐ Yes		b. Were aut prior to c death? 1 ☐ Yes	topsy finding ompletion of 2 \(\square\) No	is available cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	0.EEE/0	tiont 0000	OA Oth	or:		Check only o				
יס ר	ig Physter this neral di	n: To	27. Manuter of Death	28a. Date of Inju			28c. Injui Wor	4 L NU	rsing Home		dence 6 🗆 C now injury occ		ity)	
visior	Attending or death. ector: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determir	tion of be 28e. Place of in	ury - At home, fari	М	10	Yes 2⊡i	-	f. Location (S	Street and Nur	mber or Ru	ral Route N	umber,
Ö	To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge,	death occurre	d at the ti	me, date an	nd place, an	nd due to the	cause(s) and	manner as	stated.	-(-)
	thin 24 the Fu	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st			9c. Licens		ain occurred		29d. Date sign			
)	To cor		NA.Z	.HEGA	ZIM	7	24	41	64		Decer	nber :	3, 200	07
	8		30. Name and address of person w 10. Name and address of person w 11. Date filed (Month, Day, Year) 12. DEC 1 1 20	no completed cause of c	death (Item 23a) (T	rype, Print	ede	uch	MC	217	202	4.	Z. († ¹	-6HZ
	Sta Registr		31. Date filed (Month, Day, Year)	07 Flante	rars Signature	redi!						_		
DH	MH 17 Rev 1/2	001	DEGIT											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:38 ам Angelina Valtos November 18 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Arden Court Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Davs 1 □ M 2 🖾 F Yrs. Director 80 May 30, 1927 Tennessee 579-30-4202 Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10a. State 10h County or 28a-1 show Examiner must be notified at 1 ☐ Yes 2 K No Director Marvland Montgomery Silver Spring 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Items 23a U.S.A. 2505 Musgrove Road 20904 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced netural Completed The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: if item 27 is marked other that any injury or other traumair. Graphic Artist National Trucking Assoc. 7 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Omar Lampas Maria Karyandithis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen E. MacDonald - Sister 3102 Hollister Hill Road, Marshfield, Vermont 05658 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/4/2007 * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Surprat Service 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transli Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Box 68760 attending physician Physician/Medical Osteoporosis IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the Yes 2 No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 1 Yes 2 👿 No Division of Vital or Attending Physician: after death. Director: After this certification director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Other: 1 Tes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Living 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20274 November 19, 2007 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, M.D., 7710 Bradley Blvd., Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 2 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 17 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** Marie Vandermolen 0437M 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Medical Annapolis Anne Arundel Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Funeral Year Months 1 ☐ M 2 🔀 🖺 Days Hours 0 N/A Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State the Madical Examiner must be notified at 1 Tes 2 Totalo Stevensville Completed by Funeral Director Annec 101. Zip Code 21666 10g. Citizen of What Country? 10e, Street and Number ò United States Items 23a 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 5 1 ☐ Yes 2 ☐No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygien Important: if Item 27 is marked other tt any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vandermolen Tenniter Garry Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) father Stevensuille, Md. 21666 306 Bay City Rd. George Vandermolen 3altimore. 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 11/23/2007 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Euneral Sérvice Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PCASTIC **Physician** minutes /Medical PREMATURITY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PREMATURE RUPTURE OF MEMB 23e. Did tobacco use contribute to the cause of death? of Vital Records, MEMBRANESI TYPES 2 NO 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient 2 ER/Outpatient 3□ DOA his 27. Mann of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number D-00 205/3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAURENCE PROCEPTION 2003 MEDICAL LAURENCE ANNAPOCIS,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE TIFM TAPATH SEPARTMENT OF Wealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/22^{Day}2007 **Physician** Lindsay Ann Vandermolen 2:30pmM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11/20/2007 1□ M 2 F N/A Hours Maryland Director Usual Residence of Decedent r 28a-f show notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Stevensville MD Queen Annes 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in USA 21666 306 Bay City Rd. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🍇 No White Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If item 27 Is marked other than injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennifer Marie Srazier George Vandermolen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Bay City Rd. Stevensville, MD 21666 George Vandermolen/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Metro Crematory 11/23/2007 Baltimore, MD 21. Signature of Funera Service Lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Extreme dall /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) P.0. ☐ Yes 2 No detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certificate Kalem 1∐ Yes Physician: 25. Was pase referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ DOA 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47158 November 23, 2007 MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 6 2007

2003 Medical Parkway Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2007 11:00 AM MARGARET SHELTON WALL December 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4/19/1930 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖫 F 243-42-5652 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baldwin 1 ☐ Yes 2 ☑ No MD Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code **USA** 13724 Baldwin Mill Road 21013 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luther M. Shelton Lucy J. Wilkes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Brantley Wall, Sr./Husband 13724 Baldwin Mill Road, Baldwin, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Mem. Gardens 12/8/2007 Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licen 17314 Harkins Funeral Home, Inc., Delta, PA Part 1. Index the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or iterat failure. List only one cause on each line. Immediate Cause (Final disease or condition CELL UUNI MARCH 2006 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of). ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSACE 1 ☐ Yes 2 🕦 No

Physician /Medical **Examiner**

be executed

P.O. Box 68760.

Division or Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

physician a attending pl ed by the signed by t d be detach peen certificate has this funeral After

20

burial-transit Exami Physician/Medical þ Completed Be 2 To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: 27. Manner of Death 29a, Certifier Medical

5 Pending investigation 6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

NECEMBER 2, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ST, SUITE 209 DANIEUE DOBERMAN, ME 6565 BALTIMORE, MO 21204

29c. License number

D64395

State Registrar

29b. Signature and title of certifie

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene γ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician ALICE WEHAUSEN JANE 10:29A M 2007 DEC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL JOHNS BALTIMORE
If Under 1 Year 1 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🖫 F Director 577-76**-**7812 FEB. 1,1955 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 □ Yes 2CNNo item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director MD CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A.

14. Race - American Indian, 4363 ROCK COURT 20602 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after to nand Mental Hygiene. 1 ☐ Yes **2** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 20 No 1 ☐ Yes 2 🔀 No Specify Specify: ģ 3 Nidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 DIGITIZER DRAFTER WASHINGTON GAS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THURMAN FRANKLIN CHANEY SADIE M. THOMAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. MICHAEL WEHAUSEN/SON 6006 BOBCAT COURT WALDORF, MARYLAND 20603 e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DECEMBER 10, 2007 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM. GRDNS. 21. Signature of Funeral Service 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. ny Jal 5635 WASHINGTON AVENUE LA PLATA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CEREBRAL BLEEDING Physician NTRA minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner weeks CHOLANGIO CARCINOMA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner WERKS anding physician and use as the burial-transit -IVER FAILURE be exect Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 No certificate 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Iniury 1 Yes 2 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Box 68760, P.O. Division or Vital Records,

3altimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year) DEC 1 1 2007

29b. Signature and title of certifier

pana Prakasa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





MD

29c. License number

00059554

29d. Date signed (Month, Day, Year)

DEC 3, 2007

BALTIMORE IMD-21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 17, 2007 **Physician** Hazel M. Watson 4:46 A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye August 25, 9. Birthplace (State or Foreign Country)
Louislana 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2000KF Director 578-44-3139 76 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Prince George's Capitol Heights Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 5606 Sunbury Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HDElementary/Secondary (0-12) College (1-4or 5+) Clerk-Typist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cynthia Bryant Mack Bryant ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5606 Sunbury Court Capitol Heights, Maryland 20743 Deborah A. Gleaton(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park November 24, 2007 Landover, Maryland Rollins Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Fungral Service Licenses 4339 Hunt Place, N.E. Washington, D.C. 20019 7). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sb ck, or heart fail Immediate Cause (Final disease or condition resulting in death) in feria **Physician** /Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 🏋 No 24a. Was an autopsy 2 🔯 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2√7 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ျ 1 🔯 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 22211 11/19/07 Ru = 302 Lankan and 20706 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

KO

31. Date filed (Month

A100 GOOGLACK Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			For State	State	of Maryl		partment of Fertificate of		nd Menta			07	39740
			Registrar 1. Decedent's Name (First, Middle,	(ast)			ertificate of	Dealii	2. Dat	e of Death	J. NOZ. U	UI	3. Time of Death
	Physicia	an	Melvin Anthor		iams				Mo		Day 2007	Year	0104 M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of I		• 1/ ₉		y of Death	0104
	LAAIIIII	C1	Prince George	Hospital			Chever1	v			Princ	e Geo	roe
4	Funeral		5. Social Security Number	6. Sex		yrs. last birthda		If Under 24	Hrs. 8. Dat	e of Birth onth, Day, 1	rear)	9. Birth	place (State or Foreign
	Director		251-86-3839	1 X M 2 □ F	56	Yrs.	Indiana Bayo		08-(02-19	51		Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or	Location						10d. Inside City Limits
	Maryli f sho ied at	or	MD Prince	George		Po1+	sville						1X Yes 2 No
	the 28a-	rec	10e. Street and Number	George		DET	10f. Zip Code			100	g. Citizen of	What Cou	ntry?
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	deat	Funeral Director	11. Marital Status		cedent Ever	in U.S. 1	3. Was Decedent of H If Yes, specify Cub:		n? (Specify Ye	s or No- etc.)		ce - Americack, White,	
2	or ite	y Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes, G	2 ⊠ No aive		1 ☐ Yes 2 ☒ No	Specify:	,	,	Speci	60	
Ś	hours tural"	ed by	3 Widowed 4 Divorced	Year or	Dates:	16a Da	cedent's Usual Occup	ation		16	6b. Kind of E	втас	
2	in 72 "nat	Completed	15. Decedent (Specify only highes	t grade completed		(Gi	ve kind of work done b. DO NOT use retired	durina most o	of working	'	ob. Killa of L	00011000011	Mustry
7	iene.	шо	Elementary/Secondary (0-12)	2	(1-4or 5+)		Cook			Go	olden	Corra	al Restaura
2	e filed Il Hyg other rent,	Be C	17. Father's Name (First, Middle, I	Last)				18. Mother's	s Name (First,	Middle, Ma	aiden Surna	me)	
0	uld by Menta Irked Itic e	ToE	Unknown					Kath	erine	Will	iams		
Ē	2 sho and l is me		19a. Informant's Name/Relationsh			19b. Ma	illing Address (Street	and Number	or Rural Route	Number,	City or Towr	n, State, Zij	o Code)
2,2	and lealth m 27 her tr		Linda Jackson	Williams			24 Cherry position (Name of	Hill R	d. Belt		le MD 0c. Location		
5	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 【③ Cremation		n State	cemetery, c	rematory or other pla						
	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Sprvice I			hesapea	ake Cremat				Beltsv	ville	, Maryland
ם מ	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service to	Dan	MIC	136/	22. Name and Addre						
E	P 62		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the	death. Do not	enter the mode of dyir	ng, such as ca	ardiac or respi	ratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ere Hy	noxia							Onset and Death
	/Medical		resulting in death)	a		nsequence of):							
	Examiner		Sequentially list conditions.	D	umonia						_		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			nsequence of):	D:						
	and and II-tran	хап	that initiated events resulting in death) Last			sequence of):	Disease					-	
5	cate be executed physician and the burial-transit	ia E)	Hep	atitis	s-C							
2	ificate g phy: as the	edical		0									
5	h cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome pf pr		3 □Ectopic pregnanc	.,				ate of deliv	,
	deat e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time		5 ☐ Other (specify) _	у			Ĭ.	1onth	Day Year
ב ב	at the	Phy	9 Unknown			10 10 1 10	1.1 (and Death	0.0	a Did toba		atributa ta t	the course of death?
į	res th	by	Part II. Other significant condition Severe Anemia	_		resulting in the	e underlying cause giv	en in Part I.	20		acco use con s 2 □ No	3 □ Pro	the cause of death? bably 4 X □Unknown
5 25,	requi	eted											
ב	e law has t je 2 s	Completed							24	a. Was an autopsy perform		prior to co death?	opsy findings available ompletion of cause of
<u></u>	n: Th ficate r, pag		05.00							Yes 2	No	1 ☐ Yes	2 No
=	siciai certii irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient	2 ER/Outpa	ient 3 DOA Oth	or:	of Death (Chec		,	thes (Case	16.1
5	Phy er this eral d	: To	27. Manner of Death	28a. Dat	e of Injury	28b. Time	e of 28c. Inju		sing Home 5 28d. De		w injury occu		ny)
5	nding th. r: Afte e fune	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	9 1 .	onth, Day Yea	ar) Injur		rk? Yes 2∐N∈	0				
2	Atternation of the part of the	ifice	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Plac	ce of injury -	At home, farm,	street, factory, office			cation (Stre		nber or Rui	ral Route Number,
5	rtal or rs afte ral Din	Certification:											
	To the Hospital or Attending Phystclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Examiner: On the			eath occurred at the ti r investigation, in my						
	To th within To th comp	Me	29b. Signature and title of certifier	Jo.	H		29c. Licens			29	d. Date sign		
			CHU	wat you		Mil	D21	883			Nov.	19,2	007
	Transpooling.		30. Name and address of person		use of death								
	5		Hema P. Adla 31. Date filed (Month, Day, Year)	, M.D.	Registrar's	9470 A	Annapolis	Road,	Suite	#315	Lanha	am, M	d. 20854
	Sta Registr		NOV 2 6 200	17 Apr.	A	Signature	W						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:50 pM November 2007 Robert Frank Wyatt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F 79 Director November 28,1927 Connecticut 579-26-6695 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ıral", or İtems 23a or I Examiner must be r U.S.A. 12419 Connecticut Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩II 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ White 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Retail Manager Hardware City 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F 7 Is marked ot 1 and 2 should be Mabel Catherine Platt Harry Oxton Wyatt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 12419 Connecticut Avenue, Silver Spring, Maryland 20906 Barbara A. Wyatt - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 11/28/2007 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 6 \sim 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician multiple mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No. 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed. the Funeral Director: After this certificate mpletely filled in by the funeral director, pag 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury
(Month. Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

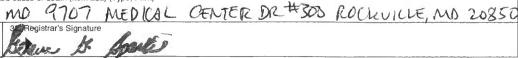
31. Date filed (Month, Day, Year)
NOV 2 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STOS

29b. Signature and title of certifier

GEOV26E



29c. License number

D43083

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Anthony Whitaker Iro Month Day 1245 PM 11 2007 seorge /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Hours | Min. 43 Arundel Medical Anne Arridel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₽M 2□ F 213-15-Maryland Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md. hester tnne's veen 10g, Citizen of What Country? 10e. Street and Number 'natural', or items 23a or 21619 ted States 1836 Sherman Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mever Married 2 Married 1 Yes 2 Yo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♠No Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than ' Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Anthony Whitaker Sr. LUSha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trains 21619 1836 Sherman Dr. Chester George Anthony Whitaker-Sr. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov.19, 2007 Chester, MD 4 ☐ Donation 5 ☐ Other (Specify) Chester ametery 22. Name and Address of Facility Henry Puneral, Home, P.A. 21. Signature of Funeral Service Licensee welle C 510 Washington St. Cambridge, mb 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ノダイ /Medical Due to (or as a consequence of): Examiner GM Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aus to (or as a consequence of): Examiner that the death certificate be executed 10 attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 4 No 3 Probably 4 Unknown as been signal 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? page certificate 1∐ Yes 2 No After this certification funeral director, it Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 → No 1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 21401 2001 mapolis State 2007 Registrar

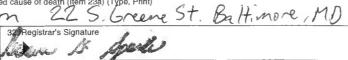
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** 20 M /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Redical Center N/A Baltimore 8. Date of Birth (Month, Day, Year)
Tan. 3,1963 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **™** 2□ F 218-78-0958 44 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Maries! 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A MDBaltimore 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 712 Allendale St. 21229 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4or 5+) Personal Trainer Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Clarence Bailey Brenda J. Bailey P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Allendale St. Baltimore, Maryland 19a. Informant's Name/Relationship (Type. Print)
Brenda J. Bailey/ Mother 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 2 / 1 5 / 0 de 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery Pikesville, MD 4□Donation 5☐Other (Specify)Entombmen 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Egheral Service Licensee E Log 5240 Reisterstown Rd. Baltimore, MD 21215 Approximate Interval Between Onset and Death 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Omin **Physician** Castromtestina disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** patocella Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine patitis The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (r as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE signed by the attendin d be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3

State Registrar 31. Date filed (Month, Day, Year) **DEC 1 2** 2007

Ka



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amenbd #8 Per File 6874 12714/07 JH Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1- State Registrar Amend Items 26 per verb.,8874,12/12/074112 ate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2 2007 ear **Physician** Ellen 7:00 A Mary Ayers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 22 Greenwood Avenue Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M January 3 1936 Baltimore, Maryland Director 219 34 0301 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liny or other traumatic event, the Medical Examiner must he provided only. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Baltimore Baltimore County Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA 22 Greenwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Dixon Unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3507 Beach Road Middle River, Maryland 21220 Kevin Kauders (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. December 6 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Spart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final 24 Ray **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or, Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical the as Box (23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☑ No o 9 Unknown ₫. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 XYes 2∏ No Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 LN0 1 🔲 Inpatient 2 TER/Outpatient Certification: To this 27. Manne Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division (Month, Day Year) or Attending 5 Pending investigation 1 ___ atural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide after within 24 hours a'
To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) npletely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) 6730 Holabird Avenue Dundalk, Maryland 21222 Ali Sanai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 9, 2005 Donie runtis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner big Howard Comf COL 140501441 General If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, OCt. 14 7. Age (In yrs. last birthday) ^{Year)} 1933 Days **Funeral** Months Hours 1 ☑ M 2 ☐ F 226-40-0308 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2√ No **Elkridge** Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 USA 6547 Vaile Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ₩ Widowed 4 Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta Kyle Armbrister Adams George W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kelly Mckenny 6547 Vaile Drive, Elkridge, MD 21075 (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Grematory Inc. 2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Euneral Service Licen 23a. Part. Enter the disease, or complications that cause the death from the shirt, or heart failure. List of yone cause on each line. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death the death ponot enter the mode of dying, such as cardiac or respiratory arrest, da **Physician** /Medical Due to (or as a consequence of): Examiner Stophylococcus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Ves 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s has 2 - No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 Tes 2 No 1 Unpatient 2 ☐ ER/Outpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 5 Pending To the Hospital or Attending 1 Natural 1 TYes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760亿

Patoxent

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

2007

32/Registrar's

1200

31. Date filed (Month)

07-09362		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legi	ble.	
James Anthony			ygiene	201	17 39741
		1- For State Certificate of Death	Reg	. No. 201	01 0014
Physici		1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death
Medical Exami		JAMES ANTHONY BOWMAN III	Month December 3	3, 2007	0950 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	th
		4206 Thayer Court Baltimore		J.	A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. B	
Director		Months Days Hours Min	Trans	Fore	ign ountry) # ## a a t is a ##
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with t	a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian, Black,
ath v	Funeral Director	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	
er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: 13	IAOV
2 hours after "natural",	by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business	Z/TC/
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n 72 n 72 ical)et	Elementary/Secondary (0-12) College (1-4 or 5+)		AL /	^
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21215-0036 wild be filed within? Mental Hygiene. marked other than	ပ		e (First, Middle, Ma	alden Sumanie)	indead
21 be f ental rrkeq	Be	JAMES A. COWMAN JR. I ASH	レヒリ	001	TNOON
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	L L	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural R te Numb	er, City or Town, Sta	te, Zip Code)
MD nd 2 sho alth and m 27 is		ASHLEY TOHNSON (MOTHER) 4206 THAVER	C1. L	DALTO,	14021225
e, land Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) 1 V Ruriel 2 Comption 3 Removal from State crematory or other place)	Date /	20c. Location - City	or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		Dullar 2 Cremation 3 Removal norm state	11 17	BNITH	LOF MA
t. Partmentran		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility (2)	11-01		TORE, MD
Balti permit. Departn Import		21. Signature of Pulleral Service Licensee	ROWN		RAL HOME
		Liebuch N. Willam 2140 N. FULTO	NAVE,	BALTO.	MD. Q/Q/7
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/Medical xaminer	Ĺ	Immediate Cause (Final disease a. Bronchiolotitis with focal acute broncho neur	nonia		Death
Adminer		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b.			
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	<u> </u>	cause. Enter Underlying Cause (Disease or injury that initiated			
W B E	ığ.	events resulting in death) Last Due to (or as a consequence of):			
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Division of Vital Records, P.O. Box 68760, and ratending Physician: The law requires that the death certificate be as after death. The this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	′
68 ertifi ding e as t	au	23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year
ath coatten	sici	4 Pregnant at time of death 5 Other (Specify)			İ
Be deg	Phys	9 Olikilowii	Loo Billio	<u> </u>	1. 1b
b.O. E that the d ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
res the signer be d	d by	Co-sleeping in an atypical sleeping environment	1 Yes	2 No 3 P	robably 4 🗹 Unknown
ds requi	ompleted		24a. Was a		autopsy findings available
cor law has t	ldu		autops perform		o completion of cause of ?
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for t	Con		1 ✓ Yes 2	No1 ✓	Yes 2 No
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. The this certificate has been signed completely filled in by the funeral director, page 2 should be determed.	Φ	25. Was case referred to medical 26.Place of Death (Check			
Vit ysici dire	0 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursi	ing Home 5 F	Residence 6 🗸 Ot	ner: Scene
of g Ph	<u> </u>	27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
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Divisior Spital or Attend hours after death. meral Director:	Ö	4 Homicide Tourid. Testueice			
e Ho 124 b e Fu	g	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause	e(s) and manner as s	tated.
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director. completely filled in by the fi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	no piace, and due to	the cause(s)
F % F S	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (1	Month, Day, Year)
		h h, no		December 4, 2	007
		20. Name and address of passes who completed asses of death (flow 22c)			
d		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
\sim					
	tate	31. Date filed (Month, Day, Year) 32 Signature			
Regis	ırar	DEC 1 2 2007 Blow & 1900a			
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Month **Physician** 6, Madeleine Sullivan 10:27 AM Beirne Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Director 151-61-8143 31 1, 1976 Feb. NJ Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iges 1 and 2 should be filed within 72 hours after death with it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or i or other traumatic event, the Medical Examiner must be nor the traumatic event, the Medical Examiner must be nor hear traumatic event. 3101 Ferndale Street 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No à Specify White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired)
Administrative
Review Specialist DC Child & Elementary/Secondary (0-12) College (1-4or 5+) Family Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Heatth and Mental I Important: If Item 27 Is marked ot any Injury or other traumatic even Madeleine Walsh 2 William F. Sullivan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Ferndale Street Kensington, MD 20895 Kevin Beirne - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-11-2007 Fairview Cemetery Westfield, NJ 21. Signature of Funeral Service License 22. Name and Address of Facility Higgins and Bonner 582 Springfield Avenue, Westfield, NJ 07090 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Anoxic Encephalorathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an

page 2 s certificate Be မှ this funeral Certification: After

Physician: or Attending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fun

Division

2

Medical

State Registrar 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

and manner stated.

1 X Inpatient

(Month, Day Year)

28a. Date of Injury

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 26056063

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy perform

28d. Describe how injury occurred

1□ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

20817 7010 Winterberry Lane, Bethesda, MD Kanwaljit K. Nagi,

31. Date filed (Month, Day, Year) DEC 1 2 2007

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

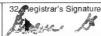
1 Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of I	Marylan	d / Depa	artment of H	lealth a Death	and Ment		ne2007	39748		
	5 -	4	Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death								140.	3. Time of Death		
	Physici /Medio	cal	Jennie J. Bany	December 9, 2007 648 PM										
9	Examiner 4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital						4b. City, Town, or	Location of	f Death		4c. County of Death			
139						la at hirthday)	Lanham If Under 1 Year If Under 24 Hrs. 8.			Prince 3. Date of Birth		eorge's		
	Funeral Director		139-01-5681	1 M 2 M F	Age (In yrs. I	Yrs.	Months Days	Hours	Min. (M	onth, Day, Ye	ear) Cc	thplace (State or Foreign ountry) W Jersey		
_	pu. »		Usual Residence of Decedent 10a, State 10b, County		100 City	y, Town or Lo	cation					40d Inside Other Limite		
/	shov dat	5					Cation					10d. Inside City Limits 1 ☐ Yes 2 🕅 No		
)	he M 28a-f otifie	ecto		George's	Lanh	nam				140				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may hiury or other traumatic event, the Medical Examiner must be notified at once.	Ë	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	ountry?		
		<u>ra</u>	9885 Greenbelt R			0 140 1	20706				S.A.	atan ing adalah		
)		un n	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig ın, Mexican	gin? (Specify Y , Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whi			
36	saft ;or (ami	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	1		1 ☐ Yes 2 No Specify:				Specify: White			
21215-0036	hour tura	ba	15. Decedent's E	dent's Usual Occup	ation		16	6b. Kind of Business/Industry						
15	in 72 n "na fedio	Completed	(Specify only highest gr	kind of work done o	durina most	of working	1	ob. Itilia of basiless/litaustry						
12	with iene. thar	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)			les			R	etail			
	filed Hyg other ent, i	BeC	17. Father's Name (First, Middle, Las	t)		54.		18. Mother	r's Name <i>(First</i>		den Surname)			
Maryland	ld be ental ked o	To B	Steve Abahazi					Mar	y Toron	vi				
Z	shou nd M mar	Ĕ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a		<u> </u>		ity or Town, State,	Zip Code)		
	nd 2 alth a 27 is r trau		Joyce A. Angyal	(Daughte	r)	1					g, MD 20			
<u>6</u>	F Hearten		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place		Date		. Location - City or			
) E	Page ent o nt: If		1 K Burial 2 □ Cremation 3 E 4 □ Donation 5 □ Other (Speci		ite		Cemetery	· i	12-14-0	7 Ho	pelawn, 1	V T		
Baltimore,	nit. F artm ortar Injui		21. Signature of Funeral Service Lice	**	1001		-			110	perawn,	NO.		
B	Physician /Medical Examiner		21. Signature of Funeral Service Licence 22. Name and Address of Facility Mitruska Funeral Home 531 New Brunswick Ave., Fords, NJ 08863											
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause on each	sed the death n line.	n. Do not ent	er the mode of dyin	g, such as	cardiac or resp	iratory arrest,		Approximate Interval Between		
			Immediate Cause (Final disease or condition	2	Hym	r tens	Sim					Onset and Death		
1			resulting in death)	Due to (or	as a o n equ	uence of):						7640		
8			Sequentially list conditions.	b	Dionetes Mellitus							yeu. 5		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):								
	and trans	Examiner	cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
50,	oe ex	Ω Ξ	Todaling in doubly East	Due to (or	as a consequ	dence ot):								
8760,	icate be executed physician and the burial-transit	dical		▲d										
Θ	leath certific attending p	Me	IF FEMALE:	Ogo If you outcom	mo of oromo	-								
Вох	attend for us	ian						Ectopic pregnancy			23d. Date of delivery Month Day Year			
	the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
P.0	that the de ned by the a detached t	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
Division or Vital Records,	requires been sign should be	d by	•	isonymy outdoo green arr tare.			1 Yes 2 No 3 Probably 4 Inknown							
Ö		Completed	04-11/-							ta. Was an	n 24b. Were autopsy findings available			
Re	has las ge 2 s	m							2	autopsy	l prior to	completion of cause of		
a			OE Man ages referred to medical	T						performed ☐ Yes 2	tNo 1 ☐ Yes	2 □ No		
Ξ	sicia certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	-111 0357	£0/0.4	t 3DDOA Othe	DE:	of Death (Che					
o	Phys r this ral di	 T	27. Manner of Death	1 ☐ Inpatient 2 ☐ EH/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify						ecify)				
on	nding P. h. After	ion	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No			201 Social New Highly Goodings				
S	tten deatl ctor: y the	ical	3 ☐ Suicide 6 ☐ Could not b	e 200 Place of	iniury - At ho	me, farm, str				cation (Stree	t and Number or R	ural Route Number		
Σi	To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Sea. Injury at Sea. Inju									tate)	arar route rearrises,		
												s stated.		
		Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									e to the cause(s)		
	Vith with Con	Σ	29b. Signature and title of certifier	1			29c. License				Date signed (Mon.			
	1		A feun	Reuse				194	46		12/10,	107		
•	25													
Troop Remse n 15/15/1/ain Street, Julie 351, Caurel, MIS, 20								1), 207	07					
	Sta	1-	31. Date filed Month, Day Year)	Sa Regi	strar's Sina	ture	2	/						
	Registr	àr				-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryl	and / Depa <i>Ce</i>	artment of F	lealth a	and Me		giene () (7	39749
	ø,		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ith		3. Time of Death
	Physici		MURDOCK TYL	OP BII	RTON.	Jr.			Т	Month Decembe	Day r 8 20	Year	8:00 P. M
	/Medic Examin		4a. Facility Name (If not institution,	01.	4b. City, Town, or Location of Death				oer 8, 2007 8:00 P. M				
	LXdiiiii		Broadmead				Cocke	vevi11	م ا		Baltimore		
	Funeral			6. Sex	7. Age (In)	rs. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		268-28-9793	1 X M 2 ☐ F	83	Yrs.	Months Days	Hours	Min.	(Month, Day Feb. 10	1924	Ohi	
	ט		Usual Residence of Decedent								, , , , , , , ,		¥
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Items 23e or 28e-f ehow importent: It item 27 ie marked other then "naturel", or Items 23e or 28e-f ehow any njury or other treumatic event, I're Modical Examiliant is used to inclined at once.		10a. State 10b. County		10c.	City, Town or Lo	cation					1	0d. Inside City Limits
		cto	Maryland Balti	imore		Cockeys	ville						1 ☐ Yes 2 No
		Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr								ntry?		
		al	13801 York Road	d Q-12			21	1030			U.S	S.A.	
		Funeral	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spec	eity Yes or No-		e - Americ k, White,	can Indian,
9	or lt		1 ☐ Never Married 2 🎇 Marrie	d 1 ∑Yes	2 No		1 ☐ Yes 2 💢 No	Specify:	,, , , , , , , , , , , , , , , , , , , ,		Specify		otc.
21215-0036	urel',	To Be Completed by	3 Widowed 4 Divorced	Year or	Dates: 194	3-43	21				зроспу	Whi	ite
5	72 h		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. (Specify only highest grade completed) (Give kind of work done during most of working						16b. Kind of Bu	siness/In	dustry		
2	vithin ne. ben		Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Business Consultant Fin										
	lled v Hygie her t		17. Father's Name (First, Middle, L.		ears	Bus	iness con			(First Adidde	F1na Maiden Sumam	ance	
an of	be fi									(FITST, MIDDIE,	маюн зитат	θ)	
Ĕ	nark natic		Murdock Tylor 19a. Informant's Name/Relationshi			401 14 111		Ali			ahl		
Maryland	12 sh hand 7 ie m reum						ng Address (Street						
	1 and Healt em 2 ther		Laura Anne Burto 20a. Method of Disposition	011 (wife)	b. Place of Dispo	York Rd	. Q-1.	Z CO		111e, Ma 20c. Location -		and 21030
ည်	it of the ite		1 ☐ Burial 2 🗓 Cremation :			cemetery, crei	natory or other place	ce)				•	
量	rt. Partmer rtent rtent		'4 □Donation 5 □ Other (Special)		G	reen Mou	ınt Crema	tory		1-07			Maryland
Baltimore,	Departing Important Import		21. Signature of Funeral Service Li	Censee	,	Mi	Name and Addre tchell-W 500 York	iedef	eld F	uneral	Home,	Inc.	
	20 = 8 Q		Jelye P	war		(500 York	Road	Bal	timore	, Maryla	and_	21212
	-07 et 1		23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Ueath										
	Physician	is I	Immediate Cause (Fin'al disease or condition resulting in death)	_ a	+N	EUN	IONIA						24hr
	/Medical Examiner		resulting in death)	Due to	(or as a cons	sequence of):	12.						1
		پ	Sequentially list conditions,	b. — Due to	Due to (or as a consequence of):							5.0043	
	ed sit	ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence or):									
	and al-trar	Examiner	that initiated events resulting in death) Last	sequence of);									
8760,	ficate be executed physician and s the burial-transit	<u>a</u>		l .									
387	icate phys s the	edical		d									
×	± 0 a	Physician/Me	IF FEMALE:					23d. Date of delivery					
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)				Month		Day Year			
o.	0 0 0	ıysı	1										
۵.	uires that the death cersigned by the attending be detached for use	V PF	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								tobacco use contribute to the cause of death?		
ds,	uires sigr	e Completed by	MULTIPLE MUELDIMA						1 🗆 Y	1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐Unknown			
Ö	w requir been si should		ATRIAL FIBRILLATION 24a. Was a						n 24h V	prior to completion of cause of death?			
Record	The law cate has page 2 s		autopsy perform						sy p				
ā	icien: Th certificate rector, pag		35. Was case referred to medical									Yes	2 No
Viital	ysicien: is certific director,	o Be	examiner?										
Division of	Phys	-	1 Inpatient 2 LENOutpatient 3 DOA 4 LeNousing Home 5 Residence 6 Other (Specify)									y)	
on	th. After the funeral	tlor	1 Dending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No										
18	l or Attendi after death Director: /	fice	3 ☐ Suicide 6 ☐ Could no					ation (Street and Number or Rural Route Number,					
Ö	ospitel or Attendin hours after death. unerel Director: Afi ly filled in by the fur	Certification:	building, etc. (Specify) City or Town, State)										
	Hospite 24 hours Funerel etely filled		29a. Certifier 1 Certifying	Physician: To th	e best of my	knowledge, deatl	occurred at the tin	ne, date and	d place, an	nd due to the c	ause(s) and ma	nner as si	tated.
	F 24 F 6	edical	(Check only 2 Medical Ex	xaminer : On the l	pasis of examiner stated.	ination and/or in	estigation, in my o	pinion, deat	th occurred	d at the time, d	ate and place, a	ind due to	the cause(s)
	To the H within 24 To the F complete	M	29b. Signature and title of certifier	1		1, 70,	29c. Licenso	e number		2	9d. Date signed	(Month,	Day, Year)
			Barlan	e la	SAL	L M	4 Di	383	92		12-11	0/2	007
	15		30. Name and address of person w	ho completed cau	se of death (I	tom 23a) (Type,	Print)		, –		,		
			BARBARA (MRRC	UL,	M. O.	, 1380	V	ORI	K R	D., C	00	EVSVALE
	Sta		31. Date filed (Month, Day, Year)		Registrar's Si	gnature	0	/					MI
	Registr	ar	DEC 1 2 200) (Back	as De	1000	م						

Burton 12/8678Pm

Murdock

29c. License number

Ke

ORIGINAL

29d. Date signed (Month, Day, Year)

Baltimore md 21237

and manner stated.

Sa. Dr. ve

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending wheelves and Division or Vital Records, P.O. Box 68760,

death with the Maryland

State Registrar

29b. Signature and title of certifier

9000 Franklin 31. Date filed (Month, Day, Year)

DEC 1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Bowers P^{M} Catherine Anna December 9 2007 2:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 3 1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 213 34 6829 72 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director Baltimore City Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 LISA 3303 Woodring Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Housewife Housekeeping -Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Staffa Joseph Clarke ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3303 Woodring Avenue Baltimore, Maryland 21234 Albert L. Bowers (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXI Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery December 13 2007 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc
7401 Belair Road Baltimore, Maryland 21236 21. Ign tur of Fun ra Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Abdominal Sepsis Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): stridium difficile Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the use as 1 IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ coronary artery disease 2 ☐ 40 3 ☐ Probably 4 ☐ Unknown 1 Tes diaberes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy insustice ena renal 2 **1**0 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes Certification: To this 27. Ma ✓ r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Hospital or Attendi 4 hours after death. Funeral Director: A ely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier · Cynthra Small W) 00051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St Baltimore MD 21209 Ynthia Soriano Mo 31. Date filed (Month, Day, Year) State DEC 1 2 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2203 PM

NY

10d. Inside City Limits

1 ☐ Yes X☐ No

Birthplace (State or Foreign Country)

CY

2007

Baltimore

14. Race - American Indian

White

Black White etc.

Specify:

4c. County of Death

Martin's Co. 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Dihedral Drive Baltimore MD 21220 20c. Location - City or Town, State Baltimore MD 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 2 Weeks 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D63054 December 10, 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmane, Maryland 9000 Franklin Square Dine, 32. Fistrar's Signature **ORIGINAL**

State Registrar 1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifie

Majid Cine,

31. Date filed (Month Day, Year) 2

29a. Certifier (Check only one) 5 Pending investigation

6 ☐ Could not be

ours after death.
neral Director: A
filled in by the fu

within 24 hours a

To the Funeral I

completely filled

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** December 5 2007 1130AM neen Srown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Battimore
If Under 1 Year If Under 24 Hrs. Harbor 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Mopth, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2 XF 218.90.3256 43 MD 09 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at MD 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 USA 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: Completed by 3 Widowed 4 Divorced Year or Dates: "natural" 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. orrectional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOIA towards Kichard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 21225 Sister 2835 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 MBurial 2 □Cremation 3 □ R 4 □Donation 5 □ Other (Specify) Windsor Mill, MD 12/10/2007 Memorial Margin C. Greene Funeral services 21. Signature of Funeral Service Licenses Road Randal Stown MD21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** retastatic breast cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran P.O. Box 68760.5 Due to (or as a consequence of) physician Physician/Medical the attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1☐ Yes 2☐ No
9☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an page 2 s autopsy 1□ Yes 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 5 Z007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover Streetsaltimore icuteustein

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

07-0 Col

09420	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 3975
by Brown	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2007 3975
Physician/	Registrar 2. Date of Death 3. Time of Death
dical Examiner	December 5, 2007 O143 IIIS
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore
Europol	To a 1-10 with Newton Life Source Life Age (In virs. last hirthday) Life Under 1 Year Life Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	2 18 DIG 1958 1 Mm 2 F 23 Yrs. Months Days Hours Min. 9 25/1984 Foreign Country) MD
	Usual Residence of Decedent
v any	10a. State 10b. County 10c. City, Town or Location
land f show	106, Street and Number 10g. Citizen of What Country?
Mary r 28a- ed at	10e. Street and Number 100. Street and Number 10f. Zip Code 21231
ith the 23a o	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc.) White etc.
r death with the Maryland or items 23a or 28a-f shamust be notified at onc. Funeral Director	11. Martial Status 12. Was Decedent Level III U.S. 1 Never Married 2 Married 2 Married 1 Yes 2 No
s after d ral", or niner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:
natura Exami	16 Decedent's Education (Specify only highest drane completed) 10d, Decedent's Osdar Occupation (Otto time)
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21215-0036 Montal Hygiene. marked other than "mature event, the Medical Exa	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
215 be file ntal H rked o	Inomas Smith Drenda Drown
O to 5 5 5 .	19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2p Coce)
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati	20a Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If iten injury or other tr	1 V Burial 2 Cremation 3 Removal from State Community or other place)
Itim it. Pa irtmen ortant	4 Donation 5 Other Specify: 21. Size the of Funeral Service Licensee 22. Name and Address of Facility Russ Funeral Ham. P.A.
Depril Imp	Attille of Charries 7 M. 19399 W. North HVE Balto, MD 21216
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart Betraul Betraul Betraul Betraul Betraul Betraul Betraul Betra
'4 dical	Immediate Cause (Final disease a, Gunshot wound to abdomen
	or condition resulting in death) Due to (or as a consequence of):
9	Sequentially list conditions, if any, leading to immediate cause F for Underlying Cause
listi	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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ox 68760, and certificate be attending physicis or use as the burial	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
K 68 n certil	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
the death c by the atten	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O. B ires that the d signed by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown
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COTC law re law be	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 26 Place of Death (Check only one)
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should the fine of the funeral director, page 2 should the funeral director, page 2 should the funeral director.	
Fital sician is cert lirecto	b 2). Was case felered to friedcal examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other:
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ion tendir eath. tor: A	1 Natural 5 Pending Investigation 2 Accident Investigation 2 Accident 280 Place of Injury - 4t home farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
or At or At after d Direct	3 Suicide 6 Could not be
D ospital hours meral y fillec	determined (Specify) Local Street 4 V Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burity of the funeral director.	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To witi	
	O.C.M.E. December 5, 2007
١	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
1	Log Decistade Signature
Sta Registr	
DHMH 17 Rev 1/20	O TANIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend 310b, 15, 16a&b, 17, 18, 20a Cec \$22a @ DHa 6874 12/12/07eg. No. 2] 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1030 Physician ecember 1,2007 Catherine Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Death Examiner Baltmore Jaryana GRENETAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 6. Sex **Funeral** Days Months Hours Min. unk 1 ☐ M 2 🂢 F Apr 8, 1937 Director 262-56-4124 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1√□Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or 2 Examiner must be n 727 Druid Park Lake Drive #B 21217 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married black 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced d other than "natural", event, the Medical Exa 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secruity _12 Secruity Guard marked other unle 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othn any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be ည Jimmy Carl Bess Angie Mae Best 19a. Informaci's Name/Belationship (Type. Print)

Mary Land Ceneral Stospital 19b. Mailing Addiess (Fireet and Number or Rural Route-Number, City or Town, State, Zip Code)
827 Linden Avenue Baltimore, RD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Kurial 2 Cremation 3 Removal from State MI. Carmel 12/15/2007 4 □ Donation -5 ₩ Other (Specify) in state Balto.MD. Ronalu S. Wade, State Anatomy Board 655 W. Baltimore Street pirector 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hension Physician /Medical True to (or as a consequence of): 30phageal Cancer with Metastasis to Lung + Liver **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) neumothorax certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours a er death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar

7

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

or Vital

Division

29c. License number

29d. Date signed (Month, Day, Year)

Bottimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Please	Type or Pri							gible.	
	1	For State Registrar		State of Ma	aryiano		rtificate of		•	-	007	00756
	ч	Decedent's Name	e (First, Middle, Li	ast)			imodio or	Douin	2. Date of De		UU/-	3. Time of Death
Physici /Medic				Mich	nael E	. Butle	er		Month	O S	Year 2.007	11:47
Examin		4a. Facility Name (/	f not institution, gi	ve street and number)				or Location of Dea	ath	4c. County of Death		
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with I	l Dir	678 Seaw					10f. Zip Code	21220		log. Citizen	of What Coul	
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ro the vithin ro the complex	Med	29b. Signature and	title of certifier		atou.		29c. Licen	se number		29d. Date sig	gned (Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician /Medical	Decedent's Name (First, Middle, Las	COX				2. Date of Death Month /2	6 3	3. Time of Death
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nor 28a-1 show be notified at 100 Director	ARYLAND N B. Street and Number 1418 EDiSO	1 A HIGHW	ty, Town or Lo	BAL 10f. Zip Code	TIHORE 2121). Citizen of Wha	10d. Inside City Limits 1 ØYes 2 □ No It Country?
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2121 ad within giane. er then: the Me	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life. D	ent's Usual Occupa kind of work done d O NOT use retired LECTR	ttion luring most of working C / A N 18. Mother's Name	ng G	LEN L	ess/Industry
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- 402-04	Signature of Funeral Service Licens A. Part1. Enter the disease, or complete or heart failure. List complete the complete or heart failure.	N. W. Class ications that caused the deat	2	Name and Address	FULTO	ROWN TAVE.	R, FUI BALTO	VERAL HOME MD 2/2/7
Physician /Medical Examiner	shock, or heart failure. List only of imediate Cause (Final sease or condition sulting in death) requentially list conditions, and the conditions in the conditions, and the conditions, and the conditions in th	Due to (or as a conseq	ence of):	Dement				Inferval Between Onset and Death
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	4 Homicide determined a. Certifier Check only 2 Medical Exemine	28e. Place of Injury - At ho building, etc. (Specify icien: To the best of my known art. On the basis of examination of the basis of examination of the basis of examination.)	viedne death	accurred at the time	date and place of	City or Town, S	fate)	Rural Route Number,
	one) D. Signature and title of certifier Common of the c	and manner stated.	P	29c. License	number	29d.	Date signed (Mo	onth, Day, Year)
	Name and address of person who co LEON N. PA Date filed (Month, Day, Year) DEC 1 2 20	mpleted cause of leath (Item LACPAC, N 32. sistrar's Signat	N.D.	rint) VA BA	BRECK 3	30100 600		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12-05-2007 A M 7:51 Louis Conway Frank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 ★M 2 ☐ F 81 4-16-1926 Virginia Director 230-26-5035 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 1 ☑ Yes 2 ☐ No Director Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 6500 Riggs Road 20783 USA must by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Examiner Yes 2 No $\frac{1942}{1945}$ 1 ☐ Never Married 2 ☐ Married Black "natural", or 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) within 72 (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Self Employed 12 should be filed whand Mental Hygies 7 Is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ss 1 and 2 should be of Health and Menta Willie Conway Virginia Clark ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10109 New Scotland Drive, Fredericksburg, VA 22408 Sharon Brooks/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 12-09-2007 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bailey Funeral Service 22401 1207 White St., Fredericksburg, VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on pach line. Immediate Cause (Final **Physician** disease or condition resulting in death) DIDARION /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the aftending physician detached for use as the buria Physician/Medical the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed t 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**7** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 1 TYes this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After Attending (Month, Day Year) Injury 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No dea h. To the Hospital or Attendi within 24 hours after dea.h.
To the Funeral Director A completely filled in by the fi 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)
DEC 1 2 State DEC 1 Registrar

29b. Signature and title of certifier

0,

ex LN, (My BODIE MD Zel) 2. Registrar's Signature

29c. License number C 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39759 State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day P^{M} 9, 2007 8:25 Charlotte Corder December Bayne 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert County Nursing Center Prince Frederick Calvert if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex Months Days Hours 1 □ M 2 🕅 F April 23, PA 196-18-3185 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Calvert Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20678 USA 85 Hospital Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Marketing Manager Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Boyd Nieman, Sr. Ella Katherine Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela B. Diamond/Daughter 1741 Timber Ct., Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greene Condemorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 12/15/07 Waynesburg, PA 22. Name and Address of Facility Yoskovich Funeral Home 21. Signature of Funeral Service Licens 300 South Vine Street, Carmichaels, PA 15320 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

r 28a-f show notified at

ortant: If them 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be r

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other trainmatts any Injury or other trainmatts.

Director

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Completed

Be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

signed by the a d be detached for

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

funeral To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fur

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	Stage A	the, me	s Discust		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous 1 □ Unknown	al death 3□Ectopic			23d. Date of delivery Month Day	Year
Part II. Other significant conditions (contributing to death but not res	ulting in the underlying	cause given in Part i.		use contribute to the cause No 3 Probably 4 24b. Were autopsy finding prior to completion	4 🛣 Unknowr
				performed? 1☐ Yes 2☑No	death?	
25. Was case referred to medical examiner?				ath (Check only one)		
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 🔀 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)	
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fact fy)	ory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route e)	Number,
	nysician: To the best of my knominer: On the basis of examination and manner stated.					use(s)
29b. Signature and title of certifier	/	2	9c. License number	29d. Da	te signed (Month, Day, Ye	ar)

State

Registrar

110 Hospital Road, Prince Frederick, MD

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

🙊. Registrar's Signature

Jonathan Lowenthal,

DEC 1 2 200

31. Date filed (Month, Day, Year)

12-10-0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Amend #24aSb Per HY C874 12/12/07 Hertificate of Death

Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day CLARK **Physician** RICHARD 2007 DECEMBEL /Medical 4c. County of Death
BOLTIMORE 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown NorthWEST HOSPI Tal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 50 106-50-0493 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show dies! Examiner must be notified at 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 hgrade Zyears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐Removal from State 12/14/07 Owings, Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Volumen C. Greene Tuneral Srvs 21. Signature of Funeral Service Licensee iber+4 Rd. Prandallstown MD21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UA **Physician** /Medical Due to (or as a consequence of) Examiner Artery Basilar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Jivision or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

0

Medical

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

65843

29d. Date signed (Month, Day, Year)

DECEMBER, 05, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	nd / Depa <i>Ce</i> a	artment of H <i>rtificate of l</i>	lealth and N Death		ene g. No. 200	7 39761		
	Physici	an	1. Decedent's Name (First, Middle, Last)	2.0		_		2. Date of Death Month	Day Year	3. Time of Death		
Mil.	/Medic	al_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	Decembe	4c. County of Dea			
	Examin	e:	Harbar Hospi			Balti	MOLE		n/a			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country)		
S. S.	Director		194-34-8083 Usual Residence of Decedent	63				June 23,	, 1944 PE	ennsylvania		
	show d at	_	Maryland Anne Ar		ty, Town or Lo	Burnie				10d. Inside City Limits 1 ☐ Yes 2X No		
	the Mi	Director	10e. Street and Number	anacı	u i c i i	10f. Zip Code		10	g. Citizen of What C			
	h with	al Di	7900 Benesch	Court Apt.813	3	21060)		USA			
	tems;	Funeral	11. Wantai Glatas	12. Was Decedent Ever in L Armed Forces?	l.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ∐ Yes 2 XNo If Yes, Give Year or Dates:		1⊡ Yes 2√√No	Specify:		Specify:	white		
20	72 hou natura ilical E	ted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of work	ina I	6b. Kind of Busines	s/Industry		
21215-0036	within an "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>DO NOT use retired</i> Iomemaker	1)	9	House	ahold		
92	illed vi Hygie other	Be Co	17. Father's Name (First, Middle, Last)		<u>'</u>	Tomemaker	18. Mother's Nam	e (First, Middle, M		silora		
ylan	Menta Menta arked atic ev	To B	Foster	Duc	k		Ger	aldine		Runyeon		
Maryland	d 2 sho		19a. Informant's Name/Relationship (Type	•					City or Town, State,	Zip Code)		
	f Healf f Healf item 2		Christina Vi 20a. Method of Disposition	1son daughte	Place of Dispo	B9 Beech Sosition (Name of matory or other place			0c. Location - City o	r Town, State		
<u>m</u>	Page nent o ant: If ury or		1 ☒ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State I		Cemetery	12/14	./07 A	ltoona Pe	nnsylvania		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	ee A	2:			_	uneral Ho ena,MD 211			
			23a. Part1. Enter the disease, or co. pli shock, or heart failure. List on, or	ca ion that caused the dea	th. Do not en					Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)			artial	INFare	+140		Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):									
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
y.	ecuted and -transi	kami	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	allence of).							
,09289	cate be executed physician and the burial-transit	dical Examiner		540 10 (0) 40 4 00,100	4401,00 01,1							
9	rtificatu ng phy as the	/ledio	IF FEMALE:									
Вох	res that the death certific igned by the attending p be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	☐Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year		
P.O.	the de	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	deam 5	Other (specify)						
	The law requires that the ate has been signed by the bage 2 should be detache	by Pi	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	ınderlying cause giv	en in Part I.			to the cause of death?		
ord	w require been si should b	ted							s 2 No 3 1	Probably 4 Onknown		
Rec	has b	Completed						24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of		
ta	sician: Th certificate rector, pag		25. Was case referred to medical				26. Place of Deat	1 Yes 2	1 □ Y€			
or Vital Records,	Physician: r this certific ral director,	To Be	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	or:		nce 6 □Other (Sp	pecify)		
o uc	ding Pl	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe hor	w injury occurred			
Division	Atter ding r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At h	ome, farm, st		res 2 🗆 NO	28f. Location (Str	eet and Number or I	Rural Route Number,		
á	s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Special	ity)			City or Town,	State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate h completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/anis	augation in muca	union dende const	والمراجعات والمالة فالمراجعات				
	To the within 2 To the Comple	Med	29b. Signature and title of certifier	and manner stated.	1	29c. Licens	e number	29	ld. Date signed (Mo.	nth, Day, Year)		
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,	3		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	10000	A A	1.4.	e to the cause(s) onth, Day, Year) 2 10, 2007		
	Sta	te	Michorly Silver 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature ₂	JUN TOUR	idner 24	per O	917/W)	e vivis		
	Regist		DEC 1 2 2	2007 Minera	15 A	goard						

			1- For State Of Maryland / I	Certificate of Death	Reg. No./)	007 20762
	Physici	on.	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	Year 3. Time of Death
	/Medic	al 🤊	HELEN RUTH CHOBBY	4b. City, Town, or Location of Death	DECEMBER 6	, 2007 1:38 a M
Ġ,	Examin	er	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL	BALTIMORE	40. 000	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		212-24-8188 1 1 M 2 M F 80 Usual Residence of Decedent	TIS.	SEPT. 14,19	927 NEW JERSEY
	ryland how Lat		10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits YE Yes 2 □ No
	he Ma 28a-f s otifiec	Director	MD N/A BAI	JTIMORE 10f. Zip Code	10g Citizen	of What Country?
	3a or 3	I Dir	102 N. CLINTON STREET	21224		U.S.A.
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🛣No Specify:		ecify: WHITE
Maryland 21215-0036	72 hou natura ical E	ted		Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind o	of Business/Industry
121	d within 72 ho giene. r than "natu the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	\\ \text{life. DO NOT use retired}\\\ \text{IANUFACTURER}		ECTRONICS
d 2	filled Hygi ther		17. Father's Name (<i>First, Middle, Last</i>)		ne (First, Middle, Maiden Sur	
/lan	should be ind Mental marked o	To Be	JOHN S. YARD	ETHEL	MAE VanAl	RSDALE
Jan	d 2 should th and Mer 7 is marke traumatic			o. Mailing Address (Street and Number or Ru		
	1 an Teal			002 EASTERN AVENUE of Disposition (Name of erry, crematory or other place)		, MD . 21231 on - City or Town, State
<u>o</u> E	Page ent o nt: If		1 Burial 2 Cremation 3 Hemoval from State	EW CREMATORY 12/	10/07 BALT	IMORE, MARYLAND
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Sovice Licensee	22. Name and Address of Facility LILLY & ZEILER 1901 EASTERN AVI	INC. FUNERAL	
	<u>~</u> ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~		23a Part 1 Enter the disease or complications that caused the death. Do	1901 EASTERN AVI	ENUE , BALTIMO	ORE, MD. 21231 Approximate Interval Between
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Cours Henry	For I	Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death) a Due to (or as a consequence	of): School Con	- I	- Vig
Ē.	Examine	je.	Sequentially list conditions, b. Due to for as a consequence	444	rus - y by	Yu
W	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	anc		ym
00,	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence	C 11/2		3
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Box (eath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	n 3 □Ectopic pregnancy	23d.	. Date of delivery
O. B	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ Ves 9 □ Unknown	5 Other (specify)		Month Day Year
Δ.	s that the de ned by the a detached	by Ph	Part II. Other significant conditions contributing to death but not resulting	1	23e. Did tobacco use	contribute to the cause of death?
ords	w requires been signi should be		Hypan	gly come	1 ☐ Yes 2 ☐	3 □ Probably 4 □ Unknown
3ec	e faw r has be ie 2 sh	Completed			24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
ta F			25. Was case referred to medical	26 Place of Dea	1 Yes 2 No the Check only one)	1 ☐ Yes 2 ☐ No
Ž	ys dir	To Be	examiner? 1 Yes 2 No Hospital: 1 npatient 2 ER/O	Other:	ome 5 ☐ Residence 6 ☐	Other (Specify)
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Ö	ital or rs after al Dira	Certi	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Medical	29a. Certifler (Check only one) 29a. Certifler (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the cause(s) and urred at the time, date and pla	d manner as stated. ace, and due to the cause(s)
	To the within To the Comple	Med	29b. Signature and title of certifier	29c. License number		igned (Month, Day, Year)
	1) Un	024276	12	7.07
	φ		30. Name and address of person who completed cause of death (Item 23a)	()	DVI AND 0100	4
	Sta	ate	31. Date filed (Month, Day, Year) DEC 1 2 2007	BALTIMORE, MA	KITAND ZIZZ	4
	Regist	rar	DECT 2 2001 Alexander 18	arastes		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) DECEMBER^{ay}8 2007 **Physician** KYEONG HEE CHOI 2:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11007 BREWERS DRIVE PERRY HALL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. 1 M 2 X F 10/04/1960 KOREA 217 15 9959 47 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No PERRY HALL BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21128 11007 BREWERS DRIVE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or in-any Injury or other traumatic event **-*. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Specify: KOREAN ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS SECRETARY <u>12</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be S00 KWON HA SIK (LEE) KYU P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11007 BREWERS DRIVE PERRY HALL, 21128 MOON SUP CHOI/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 19ther (Specify) 4 □ Donation □ METRO CREMATORY CATONSVILLE, 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME 21. Signature Funeral Service L censee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Meta stati 8 month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Exami and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 200 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has b irector, page 2 sl performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 108 Anneslic 500040 Oliv 31. Date filed (Nonth, Day, istrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert Smith Crow Jr. secember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 83 219 18 3581 Director June 20. 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Marvland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Baylor Road 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agent Life Insurance 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Smith Crow Anna Agnes Schmidt ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Maryland 21061 Ethlynn E. Crow / Wife 206 Baylor Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 12/11/2007 Crownsville, Marvland 4 Donation 5 Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility e and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final **Physician** ereprovasujan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be exec Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 Tes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performe res 2 Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 T Yes 2 ER/Outpatient 3□ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signatur and title of certifie

31 Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2007

		For State Registrar	State of Ma	arylani	-			Death			eg. No	007	397	165
Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	th Day	Year	3. Time o	
/Medi		Donald H. Craver								December	10	2009	6:15	PM
Examir	ner	4a. Facility Name (If not institution, give		we.				Location				ounty of Death		
-		5. Social Security Number 6. Se			st birthday)	If Under	~	Mor∗ If Under				/A	nlace (State o	or Foreign
Funeral Director			X M 2□ F	71	Yrs.	Months		Hours	Min,	8. Date of Birth	935	North	place (State ontry) Caro	lina
death with the Maryland ms 23a or 28e-f show	o.	10a. State 10b. County MD Baltimore	=		Town or Lo	cation							10d. Inside C	ity Limits
28e-f	Funeral Director	10e, Street and Number		L		10f. Zip	Code			1	0g. Citize	n of What Cou		
23a or		2307 Eastridge Ro	ad			210					-	USA		
ms 2.	Jera	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13. V			spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		. Race - Ameri		
al', or Itams 23e Examination	by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		rYes,spe⊲ I⊡Yes		n, Mexicar Specify:		Hican, etc.)	S	Black, White,	etc. nite	
"netural", rdical Ex	Completed by	15. Decedent's Ed (Specify only highest grad	ucation		16a. Deced (Give life. L	lent's Usua	al Occupa	ation	et of work	ina	16b. Kind	of Business/Ir	dustry	
	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)					(OI WOIN	9	_			
1.	S	17. Father's Name (First, Middle, Last)	+10		Profe	SSOF	Fwei		arla Alama	e (First, Middle, I		ching		
0 8	To Be	Roy H. Craver						Fari			vaiden Si	ımame)		
27 is r trau		19a. Informant's Name/Relationship (7) John P. Berkensto	,, ,	er	19b. Mailin	-				a <i>l Rout</i> e <i>Number</i> imonium,				
itam r othe		20a. Method of Disposition	Damanal from Chata	20b. Pla	ace of Disport	sition (Nar.	ne of ther plac	e)	[Date	20c. Loca	tion - City or T	own, State	
Important: If ita any injury or otl once.		1 Burial 2 Cremation 3 : 4 Donation 5 Other (Specify)		ltop S	erv.	Corp).				on, Mai		
lmpo any ii		21. Signature of Funeral Service-Licens			Ru	ck To		n Fun	ÿ Τοι eral	wson, Ma Homé, I	ryla .nc.	7856 ¹ 86	ork Roa	ad
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lir	10.				g, such as	cardiac o	or respiratory arre	est,		Approximat Interval Bet Onset and	Death
sician edical		disease or condition resulting in death)	a		ance of):	neis							Weeks	
miner		Sequentially list conditions	b											
ii.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	anca of).									
and I-trans	xam	that initiated events resulting in death) Last	c. Due to (or as :	a consegui	ence of):									
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physis the			d					-						
ied by the attending physidetached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					230	d. Date of deliv Month	•	Year
5 9	by	Part II. Other significant conditions co	ntributing to death bu	ut not resul	iting in the ur	nderlying c	ause give	en in Part I			/	contribute to t		
should	eted										s 2 🗹		bably 4 □l	
has e 2	Completed									24a. Was a autops perforr	ned?	24b. Were auto prior to co death? 1 Yes	/	available ause of
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o F	2	1 ☐ Yes 2 ☑ No			R/Outpatien		-	4 🗀 NU	-	me 5 Reside			fy)	
fter	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		8c. Injury Work	·?		28d. Describe ho	w injury (occurred		
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within 24 hours are userun. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examinati	rledge, death on and/or inv	occurred estigation,	at the tim , in my op	e, date an pinion, dea	d place, a	and due to the ca ed at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due t	stated. o the cause(s	;)
withir To th compl	Me	29b. Signature and title of certifier		_		290	: License	number				signed (Month,		
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<i>'</i> U		30. Name and address of person who c	Murillo	, M	D.	Sin	as	Hasp	1 tal	of B	altr.	per 10,		
Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signatu 2	ire An			•						
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			For State of Registrar	Maryland / Dep	artment of H ertificate of I				00766					
			1. Decedent's Name (First, Middle, Last)		Tillicate of I	Death	2. Date of Death		3. Time of Death					
	Physicia		Marvel William Coffey				Month December	r 7, 2007	9:50 A M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number	per)	4b. City, Town, or	Location of Death	Decembe	4c. County of Death						
1	LAGIIIII	CI	Brighton Gardens		Towson			Baltimon	^e					
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)					
	Director		268-22-1439	79 Yrs.			April	11, 1928	Kentucky					
	w.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits					
	Maryli f sho led at	ō	MD Baltimore	Timoniu	m				1 ☐ Yes 2 [X] No					
	the 1 28a- notifi	Director	10e. Street and Number	111101110	10f. Zip Code		10	g. Citizen of What Cou	untry?					
	3a or	Ö	11298 Mays Chapel Road		21093			USA						
	death ms 2 r.mus	Funeral		ent Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Amer Black, White						
ထွ	after or ite mine		1 □ Never Married 2 □ Married 1 🛣 Yes 2	⊡∾ Korean	1 ☐ Yes 2 No	Specify:	noun, oton	Specify: Wh	_					
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show to other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 💢 Divorced Year or Dat	es:					States .					
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12	withii ene. than he M	E E	Elementary/Secondary (0-12) College (1-4		Military-	Armv		Armed Force	25					
CA	illed Hygi ther nt, t	Be C	17. Father's Name (First, Middle, Last)		111110013	18. Mother's Name								
Maryland	should be lad Mental marked o	To B	Unknown Coffey			Unkno	own	Unknown						
ary	A D E E		19a, Informant's Name/Relationship (Type. Print)	19b. Ma	ling Address (Street	and Number or Rura	l Route Number,	City or Town, State, Z	ip Code)					
	1 and 2 Health a tem 27 is		Candis Morrison (Friend		8 Mays Ch				1093					
a)	(i) O In		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from S	20b. Place of Dist	oosition (Name of ematory or other plac	ce)		20c. Location - City or						
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Balt	permit. Page Department Important: It any injury o		21. Signifure of Foreral Service Licensee	-	22. Name and Addre 1050 York				Home, Inc. 204					
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between					
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1	/Medical	Н	resulting in death) Due to (o	r as a const uence of):	-/-									
	Examiner	ارا	Sequentially list conditions, b.	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):										
7	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events . c.	r as a consequence or):										
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<u>=</u>		Son					perform 1 Yes 2	ned?, death? 2 ☐ Yo 1 ☐ Yes	2□No					
Vita	ician: The certificate har rector, page	Be	25. Was case referred to medical examiner?		Lou	26. Place of Death			A					
or Vital	di is	은	1 ☐ Yes 2 ☐ No	patient 2 ER/Outpati	ent 3 DOA	4 LI Nursing Ho		nce 6 AOther (Special of the Communication of the C	city) ASSISTED LIVING					
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ĕ	after after Dire	Certification:	4 ☐ Homicide determined buildin	g, etc. (Specify)			City or Town	ı, State)						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the ba and mann	sis of examination and/or										
	omple	Me	29b. Signature and title of certifier		29c. Licens	-		9d. Date signed (Mont						
	F > F 0		> Alrand in		1	58303		December	7 2007					
	10		30. Name and address of person who completed cause	of death (Item 23a) (Typ	e, Print)									
	["		AMON J CHARVES IN	N 6701 N	1 Charle	ST T	anson	no 212	049					
	Sta Regist	ate rar		gistrar's Signature	berte									

DHMH 17 Rev 1/2001

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William Martin C	·	I- For State	State of Maryl		epartment of Certificate of		d Menta		Reg. No.	200	7 3976
Physicia	ın/	Registrar 1. Decedent's Name (First, Mid						2. Date of De	ath	Year	3. Time of Death 1017 hrs
Medical Examin		William 4a. Facility Name (if not institute)	Martin		pbell T	4b. City, Town, or	Location of	Month December		2007 . County of Death	
·		Anne Arundel Medic	_	idiniber j		Annapolis	2000			Anne Árundel	
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	yrs. last birthday)	If Under 1 Yea			Fascian		
Director		21 3-46-1 565	1X M 2 F	61	Yr	Months Day	/s Hours	Min. June	June 30, 1946 CountryMary		
, ku		Usual Residence of Decedent 10a. State 10b. Count		100	c. City, Town or Loca	tion					10d. Inside City Limits
id how a	L		timore		Perry Hai	11					1 Yes 2 No
farylar 28a-f s	Director	10e. Street and Number				10f. Zip Code				izen of What Cou	ntry?
n the N 3a or ,		4815 Vicky	y Road			2123				S.A.	
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	uneral	11. Marital Status 1 Never Married 2 X		ecedent Eve Forces?	If `			n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - Amer White, etc.	ican Indian, Black,
ter dea	ഥ		1 Yes Divorced If Yes, Give Y		No 1	Yes 2 X No	specify:			specify: Шh	ite
ours af atural xamin	d by	15. Decedent's Education (Sp	pecify only highest gr	ade comple		nt's Usual Occupa			16b.	Kind of Business/	Industry
36 n 72 h	plete	Elementary/Secondary (0-1)	2) College	(1-4 or 5+)		chasing		55 7552)	De	elta Tele	enhone
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	Completed	12 17. Father's Name (First, Midd	fle, Last)		rui	Cilesting	18.Mother's	Name (First, Middle			3p. 101 10
215 be file mal Hy rked o	Be			ampbel					repha		
	၉	19a. Informant's Name/Relatio			1.0			er or Rural Route N Perry Hal			
, MD and 2 she ealth and tem 27 is		Carol Campbe: 20a. Method of Disposition	II / WILE		481 5 20b. Place of Dispo			Date Date		Location - City or	
nore ages 1 at of H t: If i		1 XBurial 2 Cremat		from State	crematory or c		tery	12/14/07	Fi	rederick	, Maryland
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other 21. Signature Fun Pervi			22.	Name and Addres	s of Facility			1050	York Road
Per Per lii.ii		Carl à	1. / ang	1							on,Md.21204
Physician		23a. Part I. Enter the disease, failure. List only one cau	use on each line			the mode of dying	g, such as ca	rdiac or respiratory	arrest, sh	lock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death							_		1
		Sequentially list conditions,	_{b.} Ruptured	Myocard	dial Infarction						
	ine	if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as		ence of): ardiovascular Di	sease					
<u>§</u> . 8 √	Examiner	(Disease or injury that initiated events resulting in death) Las		s a consequ	ence of):						
0, e be executed /sician and buriat - transit	dical	UNPENDED	d	D							
60, ate be shysicia		IF FEMALE:			of pregnancy		_		2	3d. Date of delive	ry
30x 6876C feath certificate e attending phys	ian/	23b. Was decedent pregnant in past 12 months?	,	e birth egnant at tim		etal death 3	Ectopic	pregnancy		Month	Day Year
Box e death c the atten ed for us	Physician/M	1 Yes 2 No 9 U	Unknown	known	ne or death 5 (Other (Specify)		73.			
s, P.O. lires that the signed by the detache	by Pr	Part II. Other significant con	iditions contributing	g to death b	ut not resulting in the	underlying cause	given in Par				the cause of death?
IS, P.	ted k										autopsy findings available
cords, law requir	Completed				<u> </u>			pe	topsy rformed	prior to death?	completion of cause of
tal Rec		25. Was case referred to med	tical T			26.Pla	ce of Death (Check only one)	s 2	No 1 🗸	res 2 No
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	o Be	examiner?	Hospital:	Inpatient	2 🗸 ER/Outpatie	nt 3 DOA	Other;	Nursing Home 5	Resid	dence 6 Oth	er:
n of V ding Ph.	-	27. Manner of Death	28a. Da (Mc	ate of Injury onth, Day,Year	28b. Time o		jury at Work		be how ir	njury occurred	
ivision or Attend after death. Director:	catio		Pending nvestigation	la an af Initia	At home form at		Yes 2		n (Street	and Number or F	Rural Route Number, City
Division tal or Attendir urs after death. ral Director: A	Certification:	de	Could not be 28e. P		y - At home, farm, str	eet, factory, office	e bullaing, etc		n, State)	and Nomber of F	draf Route Number, Oity
Hospi 24 hou Funer ely fil		4 Homicide 29a. Certifier 1 Certifying	g Physician: To the I	best of my k	nowledge, death occ	urred at the time,	date and pla	ce, and due to the c	ause(s)	and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical E	Examiner: On the bas and manne	is of examir er stated.	nation and/or investig			curred at the time, d			
	Σ	29b. Signature and title of cer	tifier				nse number C.M.E.			d. Date signed <i>(M</i> ecember 11, 2	
		30. Name and address of pers	son who completed :	ause of dec	th (Item 23a)						
(4			stant Medical Ex		111 Penn Stre	eet, Baltimore	, MD 212	01			
S Regis	tate	BEO 1	2 2007 2	kegistrar's	Signature	will					
DHMH 17 Rev 1/2		DLU I	OCME		ORIGIN	AL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 832 A M December ARTHUR DAVIS EDWARD 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 29, 194 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 2 □ F Yrs. 220-48-6134 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland | N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 2 Wyndhurst Auenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davis Catherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Melinda M. Davis 2 Wyndhurst Ave. Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loundon Park Cemetery 12-13-07 | Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Gleone enaus 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventricular fibrillation 5 minutes Due to (or as a consequence of): 48 hours acidosis metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine renal failure 10 days Due to (or as a consequence of): hepatic failure 34 years IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed? 1☐ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

be execute and burial-trar Records, P.O. Box 68760, physician the as attending p has certificate Division or Vital this After 1

Physician/Medical Completed 2 Certification: filled in by the Medical

Funeral

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be r

"natural", or

permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien. Important: If Item 27 is marked other than any injury or other traumating.

Physician

/Medical

Examiner

the Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Christine Durand 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

6 □ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL GOO NORTH WOLFE STRPET BALTIMURE, MARYLAND 32 Registrar's Signature

MediCAL DOCTOR

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Res - 000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) DECEMBER 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Fred A. Dussart December 9 200 4c. County of Deal 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death a -0500 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth al Security Number Age (Inlyrs, last birthday Birthplace (State or Foreign Country) Months Days March Pay4 Year 942 1**X** M 2 □ F 65 220-40-8152 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Middle River Baltimore 1 ☐ Yes X☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21220 24 Right Wing Drive 12. Was Decedent Ever in U.S. Armed Forces? ★□Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter Lock Insulator Elementary/Secondary (0-12) College (1-4or 5+) 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Kendal Albert L. Dussart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 24 Right Wing Drive Baltimore MD 21220 19a. Informant's Name/Relationship (Type. Print) Anna Richardson /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 12/12/07 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atherosclerone CARDIOVASCULAR dISEASE disease or condition resulting in death) Due to (or as a consequence of): VACCULAR PERUPHERAL DEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

/Medical Examiner sician and The law requires that the death certificate be executed attending physician for use as the buria Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ns 23a or 2 must be n

than "natural", or items he Medical Examiner m

Pages 1 and 2 should be fitment of Health and Mental I tant: If item 27 is marked of

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Physician

Baltimore,

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death with the Maryland

page 2 s has certificate after death | Director: / d in by the f To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

2	Chronic obs	tructive pulmontary ToisEA	\$E	1 ☐ Yes 2 [No 3 Probably 4 dunknow
Sold Inco	CARCINOMA	of the lung		24a. Was an autopsy performed? 1□ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	25. Was case referred to medical		26. Place of Death	(Check only one)	
2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othe	ne 5□Residence 6	G □Other (Specify)	
	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Section 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	?	8d. Describe how injury	y occurred
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (Street and City or Town, State)	d Number or Rural Route Number,
		rsician: To the best of my knowledge, death occurred at the tim iner: On the basis of examination and/or investigation, in my op and manner stated.			

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PFEFFEL NO 6918

29b. Signature and title of certifier

MO 21237 RIDGE RO Postto,

29c. License number

D35410

29d. Date signed (Month, Day, Year)

December 4, 200 7.

State Registrar

32. Reciprar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2007 Month **Physician** ESTHER A. DORSEY secem 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hostal Bolhmore Daltimore Ci If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X 60 219-48-2697 Director 10/03/1947 WASHINGTON, Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County MD N/A 1X Yes 2 □ No BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 5515 BOSWORTH AVENUE 21207 USA Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status "natural", or item edical Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical 72 ROSEWOOD STATE (MD) filed within Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL CENTER AIDE 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi JAMES H. MILLER MARGARET ROYCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health a ALFRED DORSEY/ HUSBAND 5515 BOSWORTH AVENUE, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department o Important: If any injury or 12/06/07 WINDSOR MILL, MD KING MEM PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death the diff ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart finure. List only one cause on each line. 23a. Park Phier the di shirt. heart find Immedia. Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (of as a consequence of): Examiner wstri Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lenal 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No spath diomy Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ∰inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Injury 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 24 29b. Signature and title of certifier

State Registrar

5-0036

Maryland 2121

Pakent Known Baltimore,

Box 68760,

P.0.

Records,

ivísion or Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

10(ma

DEC 1 2 2007

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year) December 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 2. Date of Death December 7, 2007 Shirley Deitrick 4b. City, Town, or Location of Death Columbia 4c. County of Death Howard Vantage House 6. Sex 7. Age (In yrs. last birthday)

1. Decedent's Name (First, Middle, Last) 2:55 p. **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 □ M 2 X F 578-22-7170 January 20, 1924 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Directo Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 5400 Vantage Point Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Hospital / Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental F Ruby Golden Rice Jesse Curtis Everett ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Countryside Dr. Glenwood, Maryland 21738 19a. Informant's Name/Relationship (Type. Print) Son Mr. Doug Deitrick Health Item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Вurial 2 □ Cremation 3 □ Removal from State 12/17/07 Marriottsville, Maryland Crest Lawn Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Ser Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the dise shock, or heart failure Immediate Cause (Final 0 Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-trar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 9 DUnknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4**∑**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 2 No 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 1 Tes Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Fo the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Name and address of person who Date filed (Month, Day, Year State

Registrar

1 2 2007

DEC

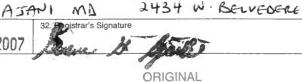
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EVANS **Physician** Month 03:10 A M HIRLEY 10 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 03/23/1929 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 224-32-8371 78 Director VA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at N/A MD BALTIMORE 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Examiner Black, White, etc. be filed within 72 hours after tal Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL ENTREPRENEUR CONSUMER GOODS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHILLIP KITTENPLAN HANNA Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau NANCY SARETSKY / DAUGHTER 111 RIDGE ROAD - ARDSLEY, NY. 10502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) BETH TORAH 12/12/2007 | RICHMOND, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TERMINAL DEMENTIA **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Each of January Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran law requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4. Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an t□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident after death Director: filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital .12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064533 12-10, 2007 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINSALE - HEFREN CHLIATRIC CTR.

State Registrar BABATUNDE M.

31. Date filed (Month, Day, Year)

DEC 1 2 2007



AVE BALTIMORE MI)

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	_1	For State Registrar			Certificate of	Death		leg. No.2	07 391	L		
ysician		Decedent's Name (First, Middle					Date of Dea Month	Day	3. Time of Dea	_		
Medical	ı	Oliver	Henry	F	ulton		Decemb	3 910	2007 09:00	PIVI		
aminer		la. Facility Name (If not institution		\	01	or Location of Death	1	4c. County				
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at		10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City L			
ctor	2	Maryland Anne	Arundel	Gibson	Island				1 ☐ Yes 2[Хімо		
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	5	10e. Street and Number			10f. Zip Code			10g. Citizen of				
ust b	0	614 Stillwater			21056			US				
er m		11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Decedent of I	Hispanic Origin? (S Dan, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Rad Bla	ce - American Indian, ick, White, etc.			
хашіл bv Fi		1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2 □XNo	Specif	% white					
ai Ex		15. Decedent		16a l	 Decedent's Usual Occu	nation		16b. Kind of B	Business/Industry			
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t, the Medical E		Elementary/Secondary (0-12)	College (1-4or 5+) +5		Executive	Director		MD Dev	elopemnt Eco	nor		
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atic ever	0	Oliver H	Fulton Sr.			Margar	^et		Stoneroad	d		
umat T	-	19a. Informant's Name/Relations		19b.	Mailing Address (Stree	t and Number or Ri	ural Route Numbe	er, City or Town				
er tra		Julis Fulton	spouse		614 Stil	lwater Ro	oad Gibso	on Isla	nd MD 21056			
oth		20a. Method of Disposition	[2	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ice)	Date		- City or Town, State			
<u>5</u>		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Li Removai from State		Crematory		11/07	Baltim	ore Maryland			
any Inju	T	21. Signature of Fun val ervice	ticens		22. Name and Addr	ess of Facility St	allings	Funera	1 Home P.A.			
E 8		Max	1		3111 Moun	tain Rd.	Pasadena	MD 21	122			
		23a. Part1. Enter the disease, or shock, or heart allure. List	o plications that caused the	death. Do n	ot enter the mode of dy	ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Betwee Onset and Dea			
cian		Immediate Cause (Final disease or condition	Para	ma	. 2				Fanc	4		
dical		resulting in death)	Due to (or as a co		/L	-1			0			
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ial-transit		Sequentially list conditions, It any leading to minimize the Course (Disease or injury) Due to (oo as a consequence of): Cause (Disease or injury)										
Il-tran	Ха	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence o	of):							
5 <u>=</u>												
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etached for use as the burial-transit	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf					23d. D	ate of delivery			
I for t	2 2	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1□Live birth 2 □ 4□Pregnant at tim		3 ☐ Ectopic pregnand 5 ☐ Other (specify)	cy		Month Day Year				
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age		Alisto SI	allation				perfo	rmed?	death?	36 01		
actor, p		25. Was case referred to medica	of clip town			26. Place of De	ath Check onl		_ ~~			
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neral c		27. Manner of Death 1 Manual 5 □ Pendin	28a. Date of Injury (Month, Day Y		ime of 28c. Injury	ury at ork?	28d. Describe I	how injury occu	urred			
led in by the funera	atic	2 ☐ Accident investi	gation		M 1]Yes 2 □ No						
tific		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		- At home, fai <i>Specify)</i>	rm, street, factory, office		28f. Location (S City or Tou		nber or Rural Route Numbe	ar,		
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ely fil		(Check only 2 Medical	ng Physician: To the best of n Examiner: On the basis of ex	amination an	, death occurred at the d/or investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and r date and place	manner as stated. e, and due to the cause(s)			
completely filled in by the funeral director, page 2 Medical Certification: To Be Compl	Jed	one)	and manner stated			nse number			ned (Month, Day, Year)			
200	2	29b. Signature and title of certifie	,	. (Sac. Ficel	iso number		Lau. Date sign	N _ A			
		Cur	reum 1	ND	<i>Dc</i>	1991c	1	Decen	most 910	20		
- 1		30. Name and address of person		h (item 23a) (Type, Print)	0 11	n Bur		1 0			
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State		31. Date filed (Month, Day, Year)	2. Registrar's	Signature	Lesphian I) (3 (0)	W 17 CHA	10,70	17 00101			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 200 December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner 14 more tospita arruland zenera 9. Birthplace (State or Foreign Social Security Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Min. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Completed by Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race -American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 M No Baltimore, Maryland 21215-0036 lac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
iffe. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gladder Mrs. Beth 20018 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ood lawn. 1510 ood lawn Cemeters 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical o (or as a consequence of): Examiner pheumonic Duration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ⊞thknown 1 🗌 Yes 2 ☐ No , page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 L No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 1 | Yes 2 | 1 | No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ∏Yes 2 ∏No 4 hours after death. Funeral Director: At ely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar

State

31. Date filed (Month, Day, DEC 1

2

Registrar's Signature

and manner stated.

32 Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

EDWARD

Physician

21237 ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown Parkinson's DISEase cancer - Prostatectomy 24b. Were autopsy findings available prior to completion of cause of death? Prostate 24a. Was an autopsy rmed? 2 No HYPERTENSION 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

FISHER

Certificate of Death

Reg. No. 2

Day

Year

2007

Baltimore

U.S.A.

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

(SAWICKA)

29d. Date signed (Month, Day, Year)

21237

4c. County of Death

400 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

21206

MARYLAND

2. Date of Death

State Registrar

burial-trar

the use as Physician/Medical

Be Completed by

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR TILAK

JoshI

attending physician

After this certificate has been signed by funeral director, page 2 should be detach

law requires that the death certificate be exect

or Attending Physician:

death.

within 24 hours after death To the Funeral Director:

filled in by

completely

b

Division or Vital Records, P.O. Box 68760,

29c. License number

9000 FRANKLIN SQUARE DR. Baltimore MD

233445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9874 12-12-07 vt
State of Maryland? Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) Jean Fleshman 2. Date of Death Kathrine Month Day Year **Physician** DEC 2007 6:45 AM 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 217 52 1578 60 Director May 30, 1947 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at 1 ☐ Yes 2 X No Maryland Howard Woodbine Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2170 Woodbine Road 21797 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Linguist U.S. Government 6 years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Anna Jane Chatnick George Rebar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2170 Woodbine Road Woodbine, Maryland 21797 Allen Fleshman / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 12/10/2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Fineral Service Dicensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IN FARCTION MYOCARAI 12 HRS /Medical Due to (or as a consequence of): Examiner MLMONAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Obliterans Organizma SEPSIS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? PUSUMONIA. 1 TYes 2□ No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18477 DEC 05 2007 CULUMBIA, MD. 21044 MO

Registrar DHMH 17 Rev 1/2001

State

11055 LITTLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD CCHAEFER 31. Date filed (Month, Day, Year)

DEC 1 2 2007

UND.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

			For State Registrar		Ce	rtificate of	Death		Reg. No.	JI	39111
	Physic /Medi		1. Decedent's Name (First, Middle, La BERTHA M. FO				·	2. Date of Dea Month DEC .	_	(∳ar) 7	3. Time of Death 6:00A M
	Examir		4a. Facility Name (If not institution, giv 2752 BAKER S			BALTI	or Location of Death	Y	4c. County o		
	Funeral Director		241-40-0243	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 10/09	h /, Year) 0/1929	Coun	ace (State or Foreign try) CAROLINA
	nand ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10	0d. Inside City Limits
	a-f sh	ctor	MD N/A	BA	LTIM	ORE CIT	Y				1 ⊈Yes 2 No
	th with the 23a or 28 ast be not	al Director	10e. Street and Number 2752 BAKER S	STREET		10f. Zip Code 212	16		10g. Citizen of Wh	nat Coun	try?
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, 6	etc.
5-0	"natu	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of worki	ing	16b. Kind of Bus		lustry
121	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	*		DUKELA NURSIN		IOME
land 2	ild be filed lental Hygi ked other ilc event, <u>t</u>	To Be Co	17. Father's Name (First, Middle, Last, BILL HEMMING				18. Mother's Name BERTHA)	
, Maryland	ges 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If item 27 Is marked other than "natural", or other traumatic event, <u>the Medical Exa</u>		19a. Informant's Name/Relationship (and Number or Rura				
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition ↑ Durial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	metery, crei NG MI	sition (Name of matory or other place EM PARK	^{ce)} 12/	14/07	20c. Location - C	•	wn, State
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of pineral Service Licer	see T. Now!	_	Name and Address Addre	ess of Facility HO BERTY HE		UNERAL AVE, BA		
68760, <	Physician physician and physician and as the prival-transit	Medical Examiner	23a. Pay Ent-r the disease, or common stock, or eart fature. List only Immediate ause (Fluid disease condition resulting in death) Sequentially list conditions, if any, leading to immediate ause (Disease or injury that initiated events resulting in death) Last		ence of):	er the mode of dying		or respiratory and	rest,		Approximate Interval Between Onset and Death
Box	eath ce attendir for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 [Ectopic pregnancy Other (specify)	y		23d. Date Mont		ry Day Year
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ו סר	g Phy ter this neral d	n: To	27. Manner of Death		28b. Time of Injury				ence 6 Other	· · · · · · · ·	")
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	Certification:	1 Autural 5 Pending investigation 3 Suicide 4 Homicide determined		ne, farm, str	M 1	Yes 2 □ No	28f. Location (S City or Tow	treet and Number n, State)	or Rura	Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 1 X Certifying Ph Medical Exam	ysician: To the best of my know niner: On the basis of examination and manner stated.	ledge, death on and/or in	occurred at the tile vestigation, in my c	me, date and place, ppinion, death occurr	and due to the deed at the time, d	cause(s) and mand date and place, ar	ner as st nd due to	ated. the cause(s)
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			Mon-	Mouns	In	003	3635	3	Decomb	iar e	1 2007
	3		30. Name and address of person who	completed cause of death (Item 2	23a) (Type,	Print)	1	~	111		
3	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 2 20	completed cause of death (Item 2	ire Const	120100	1011 Au		14000	604	MP 2025
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Doris A. Faro 11:30 A.M December 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Pasadena If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2 🗓 F 79 North Carolina May 18, 1928 10d. Inside City Limits

670 - 211th Street 5. Social Security Number **Funeral** 225 22 1903 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at Director N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a or ? must be r 1415 Locust Street 21226 Funeral "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify ģ 3 ☑ Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical any once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lonnie Ivory Hare Bessie Mae Honeycutt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Reinhardt / Daughter 670 - 211th Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages -1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 12/8/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 455 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24a. Was an perfor 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

DEC 1

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2□ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month. Day, Year)

1 X Yes 2 □ No

Approximate Interval Between Onset and Death

Moy

U.S.A.

Specify:

14. Race - American Indian

Own Home

White

Black, White, etc.

Physician

/Medical

Examiner

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of State Registrar	Cei	artment of He rtificate of D			ne No. 2007	39779		
A,	Physicia	ın	1. Decedent's Name (First, Middle, Last)	n T. Falsanar			2. Date of Death Month	Day Year	3. Time of Death 1:50 p. M		
	/Medic Examin	1.00	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson Baltimore								
	Funeral Director		230 Stanm 5. Social Security Number 218-26-4777 218-2 □ F 230 Stanm	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y November	9. Birth Cou	place (State or Foreign ntry) Maryland		
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		Movember		10d. Inside City Limits		
Maryland 21215-0036	Maryla a-f sho	ctor	Maryland Baltimore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Towson			1 □ Yes 2 No		
	th with the 23a or 28 ust be not	al Director	10e. Street and Number 230 Stanmore Rd.		10f. Zip Code	21212	10g	. Citizen of What Cou U .	ntry? S.A.		
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show snt, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Newlidowed 4 Divorced 12. Was Decer	2 □ No Pos: 1951	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	ppanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:			
	hin 72 hour e. an "natura Medical E:	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa e kind of work done di DO NOT use retired)	tion uring most of worki	ing 16	b. Kind of Business/Ir	ndustry		
	iled with Hygiene ther the nt, the	Com	Elementary/Secondary (0-12) College (1-2+1) 17. Father's Name (First, Middle, Last)			ance Engine	er (First, Middle, Ma		ineering		
	should be fand Mental I	To Be	Norwood Falcone	er				othy Hymes			
Mar	and 2 sho ealth and n 27 Is ma		19a. Informant's Name/Relationship (Type. Print) Mr. John E. Falconer	Son 19b. Maili	ng Address (Street al 517 S. Dallas			City or Town, State, Zi 1 1231	p Code)		
Baltimore,	Pages 1 nent of Ha ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place Bayview Crema	1	Date 20	c. Location - City or T Baltin	own, State		
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Lightsee	Julias	3871	Funeral Hon Old Columbia	a Pike Ellicott	City, MD 2104			
	Physician [©]		23a. Part1. Einer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition a. Myo(Au) AL INFAN(T(8)								
	/Medical Examiner		Due to (or as a consequence of):								
V	ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	or as a consequence of):					-		
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Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed by Physician/M	23b. Was decedent pregnant	ant at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of deliving Month	very Day Year		
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talF	Physician: The law this certificate has tral director, page 2 s	Be Cor	25. Was case referred to medical			26. Place of Deatl	performe 1 Yes 2 ↑ (Check only one)	d? death? PNo 1 ☐ Yes	2□ No		
or V	Physici this cer al direc	은	examiner? 1 Yes 22 No	npatient 2 ER/Outpatien		4 Li Nursing Ho	me 5 Residen	ce 6 □Other (Spec	ify)		
Division or	ath. or: After ne funer	ation:	Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	h, Day Year)	Work	es 2□No	2od. Describe flow	Injury occurred			
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)	To th within To th comp	Me	29b. Signature and title certifier	~	29c. License	number	290	Date signed (Month	, Day, Year)		
	12		30. Name and address of person who completed cause		Drint)		COALUS	M1 711	<i>(</i> 2		
T	Sta		Cyrus HAMIN 913 31. Date filed (Month, Day, Year) 82. Re	egistrar's Signature		10 100	-141-63	, , , , , ,	<u> </u>		

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/Medic	al 4
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Director 28a-f show notified at iral", or Items 23a or Examiner must be r

is 1 and 2 should be filed within 72 hours after of the third ward Mental Hyglene. The Health and Mental Hyglene. Hem 27 is marked other than "natural", or lied other traumatic event, the Medical Examines permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othnany injury or other traumatic event

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the **6** this funeral or Attending To the Hospital or Attend within 24 hours after death. To the Funeral Director: A

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Goodson 26, 2007 1400 Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2X F 81 577-30-9886 Yrs 1926 North Carolina Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No D. C. Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20002 105 Franklin Street, N. E. U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married ☐ Yes 2**X** No Yes, Give Specify: Black 1 ☐ Yes X☐ No Specify. þ 3₺ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Apartment Bldg. Elementary/Secondary (0-12) College (1-4or 5+) Resident Manager 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Plummer Ephraim Wilkins မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 994 Willis Mill Rd., Eunice M. Glover (Sister) Atlanta, Ga. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 12/08/2007 Beltsville, Md. Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. 3447 Facon Funeral Home, Inc. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Toxic Metabolic Encephalopathy resulting in death) Due to (or as a consequence of): Uremia Sequentially list conditions, the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Chronic Renal Failure Due to (or as a consequence of) Diabetes Mellitus Type 2 and Hypertension Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Anoxie Encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Cardio-Respiratory Arrest 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 [XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceg 47867 November 27, 2007 completed cause of death (Item 23a) (Type, Print) 30. Name and address person who 4701 Randolph Road Suite 216 Rockville, Md. 20852 D. Zuniga, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 2 Registrar 2007

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Exan	nine	er-	Potomac Valley Nu									•		
Funer	al		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	st birthday)	Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth			th	Montgomery 9. Birthplace (State or Foreign Country)			
Directo			445-12-5369 1 M 2K) F 95 Yrs. Months Days Hours Min. (Month, Day, Year) June 3, 1912						12 0kľá	ihoma				
and	C-10-1		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation				-		10d. inside C	Ity Limits
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r deal		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (pan, Mexican, Pue	Specify rto Rica	Yes or No n, etc.)	-	14. Race - Ame Black, White		
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al Hy		Be	17. Father's Name (<i>First, Middle, Last</i>) Horace Gilbert Crawford					18. Mother's Name (First, Middle, Maiden Surna) Mary Clyda Ruffner						
yid ould h Meni		၉	Horace Terrance Grawford											
partition by India yialing 2 LZ 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hydiene. Important: If tien 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			19a. Informant's Name/Relationship (James Terrance He				ng Address <i>(Str</i> ee Charnwoo						(ip Code)	
Healt tem 2			20a. Method of Disposition	511 (5011)			osition (Name of matory or other pla		Date			ocation - City or	Town, State	
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?		Medical		nysician: To the best of miner: On the basis of and manner sta	ot my know examination	rledge, deat on and/or ir	th occurred at the nvestigation, in my	opinion, death of	ce, and curred a	due to the it the time,	date ar	s) and manner as nd place, and due	s stated. e to the cause	(s)
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		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of fleath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar's Signature								7				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Hohn 9 2007 6:00 PM December -Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing and Rehap. Center Worcester eRlIN If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1**⊠**M 2□F Hours 89 212-12-7754 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "naturai", or items 23a or 28a-f shovedical Examiner must be notified at 1⊠Yes 2 No Director MARYIAND

10e. Street and Number OCEAN 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Bethlehen Operator 8 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I 1º BELLO ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 is m any injury or other traum once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Baltimore, Marylania 4 □ Donation 5 □ Other (Specify) Comp. Dec 14, 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility INO ST BAlto omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart fallure Immediate Cause (Final disease or condition resulting in death) Ameiscleratic **Physician** Cerve /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1□ Yes 2KNo 1 ☐ Yes To the Hospitai or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Sign and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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7) 32. Resistar's Signature

Redistrar's Signature

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			For State Registrar	State of Maryland		rtificate of l		Reg	. No 2007	39783	
	Physici	an	1. Decedent's Name (First, Middle, Las		- 11-	h		Date of Death Month	Day Year	3. Time of Death	
13	/Medic	al	Hildegarde Louisa Hahn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of					November 29, 2007 0.55 a.			
di di	Examin	er		Fairhaven				sville		oward	
i a	Funeral Director	-	211100211	ex 7. Age (In yrs. las	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y November	9. Birth Cou.	place (State or Foreign intry) Maryland	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits	
	a-f she	ral Director	Maryland	Howard		E	llicott City			1 □ Yes 2 No	
	23a or 28 ust be no		10e. Street and Number 3207 Evergreen Way	,		10f. Zip Code	21042		J. Citizen of What Cou U.S	S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 250 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:		
5-0	72 hc "natur	To Be Completed by	15. Decedent's Ec (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done o	ation during most of work d)	ting 16	6b. Kind of Business/I	ndustry	
12	within iene. than		Elementary/Secondary (0-12)	College (1-4or 5+)	nie. L		ist / Poet		A	Arts	
Maryland 21215-0036	ld be filed ental Hyg ked other Ic event, I		17. Father's Name (First, Middle, Last)	Schneider			18. Mother's Nam	e (First, Middle, Ma Lou	iden Surname) ise Luette		
_	ind 2 shou alth and M 27 Is mar er traumat		19a. Informant's Name/Relationship (ral Route Number, ott City, Mary	City or Town, State, Z land 21042	ip Code)	
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ı			23a. Part1. Enter the dispase, or com shock, or heart failule. List only							Approximate Interval Between Onset and Death	
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a conseque	Due to (or as a consequence of).						
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	nce of):							
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	rtificat ng phy e as th	Medical	IF FEMALE:							-	
P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3□	Ectopic pregnancy Other <i>(specify)</i>	,		23d. Date of deli Month	very Day Year	
ري م	s that indeposit in the standard in the standa	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death		
ord	w require been sig should b	ted b						1 ☐ Yes	2 No 3 Pr	obably 4 ⊈Unknown	
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Vita V	ician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	or.	eath (Check only one)			
ō	Phys er this eral dir	7.	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 2	R/Outpatier 28b. Time o	f 28c. Injur	v at	ome 5 ☐ Residen 28d. Describe how	ce 6 Other (Spec	cify)	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (nysician: To the best of my know miner: On the basis of examinatio and manner stated.							
)	To t To t	Ž	29b. Signature and title of certifier			D4	3725	29	d. Date signed (Month		
	6	16	30. Name and address of person who TAZIQ MAHMOUS	completed cause of death (Item 2	23a) (Type, 2a 44			MD	21157		
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 2 20	completed cause of death (Item 2) 19 Richt ye k 32 Registrar's Signatu	re So	sule)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 16:00 M ROBERT LEE INGRAM, SR. 12 08 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALtimore St Agnes HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 87 Yrs. 8. Date of Birth (Month, Day, Year) 9 / 20 / 1920 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 **X**M 2 □ F 239-24-0930 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No BALTIMORE GWYNN OAK Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 6302 LIBERTYY ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: BLACK þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT SEAMAN LANDSCAPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT INGRAM MARY CLAIBORNE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trauonce. KEITH INGRAM / SON 6803 RICHARDSON RD, BALTIMORE, MD 21207 20b. Place of Disposition (Name of commetery, crematory or other place)
MD VETERANS CEMETERY
GARRISON FOREST 12/ Date 20c. Location - City or Town, State 20a. Method of Disposition ¶ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17/07 OWINGS MILLS, 21. Signatur Funeral Service License 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 14600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the isease, or complications that caused the de for heart ailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (F disease or condition resulting in death) Cause (Final Septice Physician /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

P.O. Box 68760. Records, bber Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p GRAM IN

State

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

FETHI BENRADUANE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENRA

DUANC

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

12,08,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, Pt1, 25, 27, 28a-f. per me 98/4, 12/11/07dhb Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 6:00 PM Bruce Michael Inners November 25, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** JUL 27 1961 Days 212-50-5173 46 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1454 West 36th Street 21211 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Greaser Automotive Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles F. Inners Catherine Slenbake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 Forest Hill Road, Marriottsville, MD 21104 Charles Inners - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/27/2007 Baltimore, MD 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service License H Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Luci 21228 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Overwhelming Intechon Led to organ Failure **Physician** /Medical Due to (or as a consequence of): Examiner Probable Drug Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PAROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 bnknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 28a. Date of Injury (Mogth, Day Year)

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Found: pM 1 28c. Injury
28b. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. Place of injury 1998. 28b. Time of Injury
Found: pM 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 15 Matural 5 Pending investigation 1 ☐ Yes 2 No Unknown 2 Accident **Director**: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Found: 1454 W. 36th Street, Baltimore, MD building, etc. (Specify) Found: 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of the 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Vovember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D. Union Memoral

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

- 1 2001 person 15 popular

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12 07 6 9:3 A Daniel Jones, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5220 York Rd - Apt Baltimore
If Under 1 Year | If Under 24 Hrs. 10K 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □**X**/1 2 □ F 69 216-34-6788 10/6/38 MD **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Y∏Yes 2 No Baltimore N/A Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be 21212 USA 5220 York Rd-Apt. 10K 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 1962 14. Bace - American Indian, 11. Marital Status Black, White etc. ican filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify American <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Construction Elementary/Secondary (0-12) Laborer Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Martha Washington Daniel Jones, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5711 Bland St., Balt., MD Martha Dent-Bey/Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest VA 12/17/07 Owings Mills, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of heral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Balt., I MD 21206 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial intanction hour Physician /Medical Due to (or as a consequence of): 5 years **Examiner** disease coronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FFMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending within 24 hours after dean...

To the Funeral Director: Af 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res-000 , Medical Doctor December 11, 2007.

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State Registrar ung The Johns Hopkins Hospital, 600 N. Wolfest. Bathmore MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** R. **JENKINS** Jr. December 200 /Medical 4b. City, Τοψη, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Se If Under 1 Year | If Under 24 Hrs. In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 10/28/1941 1**⊈**M 2□F MARYLAND 219 40 2959 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No BALTIMORE Director MD ESSEX 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 340 MILES ROAD 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes XXVo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEVERAGE DRIVER ASSOCIATE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be finand Mental F ANNA MARIE MATEY PAUL R. **JENKINS** Sr ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERTA L. JENKINS/WIFE MILES RD BALTIMORE. MD 21221 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State METRO CREMATORY 12/12/07 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only or such as on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed execute. Examiner Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Jas autopsy page 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 2☐ ER/Outpatient 3☐ DOA Medical Certification: To 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending ours after death.

neral Director: A
filled in by the fo within 24 hours a'

To the Funeral C

completely filled i

death with the Maryland

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State Registrar

William 31. Date filed (Month, Day, Year)

Ilian andrew

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 Per FH G8/4 I2/I//0/ JH Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year 5: 10 PM Angela Jones 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Samaritan Hospital BALTIMORE Good N/A 5. Social Security Nur8232 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Director $214 - 56 - \frac{5232}{}$ Dec 21, 1950 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural", or Items 23a or 28a-f show Examiner must be notified at 1 □ Yes 2 □ No **Funeral Directo** Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1929 North Lexington Street 21223 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any filury or other traumatic event, the Medical Examines 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify. Specify 3 ☐ Widowed 4 ☐ vivorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARA Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George T. Boykins Mattie E. Boykins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Boykins Brother 1929 West Lexington Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ © remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/07/07 Catonsville, Maryland Metro Crematory, Inc. 21. Signature Funeral Service Lice 22. Name and Address of Facility Part I. Enter the clease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lichaemic /Medical Due to (or as a consequence of): **Examiner** CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine law requires that the death certificate be executed COVOMOUS attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Hybertension IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Analmia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 2 100 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one, Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day 5 Pending investigation 1 🗌 Yes 2 □ No after death 2 ☐ Accident filled in by the 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 12/5/07 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S601, Lock Raven Blvc SANDEEP MAYCON Good Samon tan

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, DEC

Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items
State of Maryland / Department of Health and Mental Hygiene
23a PtI,II,25 per mai 8874,12/11/07dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3:59 PM **Physician** JOHNSON ERNEST OCTOBER 20 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F Days Hours 217-28-177 **Director** 5 · a6 · 1958 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. https://doi.or/10.1007/2016.23a.or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Dves 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 2615 E. Oliver Street श्राधि Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ■ Never Married 2 ■ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Acme Aco Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel <u>Charles Ernest Johnson</u> ဥ Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun Ethel Mae Mandolph/Mother 2015 E Oliver St. Baltimore MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11.02.07 Baltimore, MD Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vayahn C. Greene Funeral Services lew 4905 York Ad Balfimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician**) HONRS MULMONTARY EMBOLLSA /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Dub to (or as a nonsequence of Examiner The law requires that the death certificate be executed burial-trar attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 Tes Completed Paraplegia due to Epidural Abscess, Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ANo 1□ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 3□ DOA Certification: To 1 💢 Inpatient 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Jivision Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 24 hours a 29a. Certifier Legitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2, To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 ai OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shuline Rao, MD. THE JOHNS HOPKINS HOSPITAL , 600 NORTH WOLFE ST., BALTIMORE ND 21787

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 1 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 9,10c,e,19b,23a per flade 98/4-12/12/07dhb, dvr Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 8=18 PM 1 Livingstone Mary 1 December 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medicul Center Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 76 **Director** 216-28-3063 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show an "naturai", or items 23a or 28a-f shov Medical Examiner must be notified at 2502 Orestvice Drive Fallston 1 ∐Yes 2 No Funeral Director MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2502 Crestview Drive 2502 Crastview 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iter any injury or other traumatic event, the Medical Examiner and. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Inc. Elementary/Secondary (0-12) College (1-4or 5+) Power & Combustion Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Kubar Josephine Koler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crestview 2502 Crastview Drive - Fallston, Maryland of Disposition (Name of Date 20c. Location - City or Town, S 21047 <u>John W. Livingstone (husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns.12/06/2007 Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 hours tailure RESTATERTURE disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Terminal Aspiration 6 hours Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sis a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed 6 weeks Altered Mental Statius signed by the attending physician and be detached for use as the burial-trai Due to (or as a consequence of): diagnosed Division or Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical 6 weeks ag Mueriple Myelimo IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate 1☐ Yes 2☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide Hospital 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar tastern Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

egistrar's Signature

Cheng

DEC 1 2 2007

31. Date filed (Month,

RES-600

Bullimore, MD 21224

December

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	•			lental Hygi	ene	
		_	1 = State Registrar	Cer	tificate of L	Death		g. No.2	39792
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3: Time of Death
	/Medic	al	Edith C. Lipman		4h City Town or	Location of Death	Decembe	r 9, 2007 4c. County of Dea	12:40 p M
)	Examin	er	4a. Facility Name (If not institution, give street and number) Gilchrist		Towson	Location of Death		Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last i	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	rthplace (State or Foreign
	Director		219-03-1450 ¹□ ^M ² □X ^F 89	Yrs.	Months Days	Hours Min.	October	13,1918	Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lov	eation				10d. Inside City Limits
	laryla shov ed at	5	Maryland Baltimore	Tow					1 □Yes 2 ☑ No
	the N 28a-f	Director	10e. Street and Number	TOW	10f. Zip Code		10	g. Citizen of What C	
	with 3a or 1 be r		615 Chestnut Ave.		21204			USA	,
	within 72 hours after death with the Maryland ene. Ithan "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11 Marital Status 12, Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
9	after or ite		1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes, Give No If Yes, Give N		Yes, specify Cuba ☐ Yes 2 No	In, Mexican, Puerto Specify:	Hican, etc.)	Black, Whi	
93	iours iral",	d by	3 Widowed 4 Divorced Year or Dates:		^\			WI	nite
5	"natı	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of work		6b. Kind of Business	/Industry
12	within iene. than the Me	ᇤ	Elementary/Secondary (0-12) College (1-4or 5+)		Maker	,		Own Home	<u>,</u>
d 2	filed Hygi other ent, ti		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M		
<u>a</u>	should be and Mental s marked o umatic eve	To Be	Claude Huesman			Mary	Kelly		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Merial Hygiene at the matter at the marked other than "natural"; or items 23a or 28a-f show item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)	9b. Mailin	g Address (Street			City or Town, State,	Zip Code)
	1 and 2 Health tem 27 l			5233				Hall, Md.	
ore	Pages 1 nent of Hi int: If Iter		1 M Burial 2 Ucremation 3 Hemoval from State		sition (Name of natory or other plac			20c. Location - City o	·
Ē	t. Pag tmen tant: ijury	- 2	4 Donation 5 □ Other (Specify) Drui		dge Cem.	12/1	2/07 P	ikesville,	
Baltimore,	permit. Pages Department of Important: If I any injury or once.	. ,	21. Signatur of Funeral dervice Licensee		Name and Addres		Home I	1050 Yo nc.Towson,	ork Road
	22240		23a Part1 Enter the disease or opmolications that caused the death. D						Approximate
	Dhtht	S 9/4	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	4.1	. 6	7 / 4	1 2 2	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a		ic m	an CH	VICERC		770701.4
	Examiner								
	D Æ	ner	Sequentially list conditions, if any body is formal and cause. Enter Underlying Cause (Disease or injury	ce of);					
V	ecute and trans	Examin	that initiated events c.	f):					
8760,	cate be executed bhysician and the burial-transit	Ē	Due to (or as a consequence	ce or):					
687	icate physi s the I	dical	d						
Box (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy					23d. Date of d	elivery
	death atter	iciar	in the past 12 months? 1 Ves 2 MNo 4 Pregnant at time of death		lEctopic pregnancy] Other <i>(specify)</i>			Month	Day Year
P.0	that the de led by the a detached t	hys	9 ☐ Unknown						
S, F	36 PG	by P	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause giv	en in Part I.		,	to the cause of death?
ord	w require been si should b						1 ☐ Ye	s 2⊠No 3∏I	Probably 4 ☐Unknown
or Vital Records,	has be ye 2 sh	Completed					24a. Was ar autops	24b. Were a	autopsy findings available completion of cause of
H		S					perform 1□ Yes 2	ned2 death? 2 No 1 □ Ye	s 2 No
Vit	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Oth	or:	th (Check only one	_	Lange
ō		<u>٦</u>	27. Manner of Death 28a. Date of Injury 28	Outpatien b. Time of	C 3 DOA	4 □ Nursing H	ome 5 Reside 28d. Describe ho	<u>``</u>	ecify) (T 3 3/1 3C
On	Attending r death. ector: After by the fune	ţi	1 ☐Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Inĵury		k? Yes 2 ☐ No			
Division	Attend ir death ector: by the f	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str. City or Town	reet and Number or I	Rural Route Number,
Ö	tal or s afte al Dir ed in	Certification:	Tallians, etc. (Specsify)				only of Your		
	• Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fi		29a. Certifier 1	dge, deatl and/or in	n occurred at the til vestigation, in my c	me, date and place opinion, death occu	, and due to the ca rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 ha To the Fur completely	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number	25	9d. Date signed (Mo	nth, Day, Year)
	F 3 F ŏ		M Anthur Kilm, mo		02	5 205	a	Combu	10, 2002
	0		30. Name and address of person who completed cause of death (Item 23.	a) (Type,	Print)	2 (1.111	111 -	20/2
	1		W. A. Kiley GPINC GTUI	N.	Murch	is 1/. 1	-20CKT3	1111 /6	20%
4	Sta		31. Date filed (Month, Day, Year) 32. Sylistrar's Signature		7-10-				
	Registi	ar	DEC 1 2 2007 Som &		3842)				

DHMH 17 Rev 1/2001

2. Date of Death Day 11.05 AM МсСоу James 12 07 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1311 Halstead Road Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1**X**M 2□F Yrs. 11/30/1906 Virginia 101 185-03-7061 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sh event, the Medical Examiner must be notified 1X Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. Funeral 1311 Halstead Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 X es 2 No 1943 If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black δ 3 ☑ Widowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) UNK College (1-4or 5+) Refinery Machine Operator permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If frem 27 is marked other any injury or other traumour. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mariah Bickon Samuel McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1311 Halstead Road, Baltimore, Maryland 21234 Lynn Crawford / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Pk. 12/17/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - Ischemic Stroke **Physician** week5 /Medical Due to (or as a consequence of): Artherosclerosis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examiner burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0044018 ungenellah 12-10-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print, Eugene A. OBAH, M.D. GBMC Baltimore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State	of Marylan		artment rtificate			and M	ental H	ygiene Reg. No	200	7	3979	94
1	Physici	an	1. Decedent's Name (First, Midd		MARTI						2. Date of D	eath Da	ıy, Y	ear	3. Time of Dea	
	/Medic	al	4a. Facility Name (If not institution	on, give street and nu	ımber) ,	IVEL			Location o		Novemb	- 1	County of			
			5. Social Security Number	PUCIST HOS	7. Age (In yrs.	last hirthday)	TQ:		Park		8. Date of E	lirth	Moutg		lace (State or Fo	mian
ï	Funeral Director		579-68-5959	1 M 2 □ F	7. Age (III yis.	Viro	Months	Days	Hours	Min.	2/19/	Day, Year,	,	Coun	alvador	neign
	and ww t		Usual Residence of Decedent 10a. State 10b. County	у	10c. Cit	y, Town or Lo	ocation							1	0d. Inside City L	imits
	a-f sho	ctor	MD Prince	e George's	в Нуа	ttsvil	.1e								1 □ Yes 2	No
	with the	Funeral Director	10e. Street and Number				10f. Zip					10g. Ci	tizen of Wha	at Cour	try?	
	ms 23	neral	4313 Oglethorpe	12. Was Dec	cedent Ever in U	.S. 13.	Was Decede		spanic Ori	gin? (Spe	cify Yes or N Rican, etc.)	USA	14. Race -			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Ma	Armed F urried 1 ☐ Yes If Yes, G	Ž No ive		Yes 2				adorai		Black, Specify:			
21215-0036	2 hours atural' cal Ex	ted b	3 ☐ Widowed 4 ☐ Divorce	ent's Education			dent's Usual		ation				Kind of Busin			
1215	ne. han "n e Medi	Completed	Elementary/Secondary (0-12)	est grade completed, College	(1-4or 5+)	life.	kind of work DO NOT use chanic	e retired,	iuring mos:)	t ot workii	ng	۸.,	tomot	-i		
d 2	filed w Hygie other th	Be Co	12 17. Father's Name (<i>First, Middle</i>	, Last)		116	CHAILL		18. Mothe	r's Name	(First, Midd		n Surname)	ive		
ylan	ould be Menta arked atic ev	To B	Nicolas Serpas	3							isa Ma					
Mar	d2shdthandthand:7ism traum		19a. Informant's Name/Relation Nancy G. Martir			1	_				attsvi				•	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	·	20b. I	Place of Disponentery, cre					actsv		ocation - Ci			
tim	tment trant tant: If		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Ch	esapea	ke Cre	emat	orv 1		The second secon		tsvil			
Ba	permit Depar Impor any in once.		21. Signature of Funeral Service	e Licensee	moo:	30-	2. Name and			nap	p Fune 1ver S				ion Svcs	
BC	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause on	caused the deat	h. Do not en	ter the mode	of dyin					g HD	20	Approximate Interval Between	
	Physician / /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a	ivrhosh	of the	Live	r							Onset and Dea	u i
	Examiner			b.	o (or as a consec	juence or):										
V	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(огав в повело	wones of):										
ď.	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c	(or as a consec	juence of):								_		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		d								-				
Box 6	certific nding p	//Mec	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn								23d. Date	of delive	erv	
	at the death certifica by the attending pl tached for use as t	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Feta gnant at time of o nown		□Ectopic pre □ Other (spe						Monti		Day Yea	ır
P.O.	res that the signed by to be detach		9 ☐ Unknown Part II. Other significant condit			ulting in the u	ınderlying ca	ause give	en in Part I		23e. Die	d tobacco	use contrib	ute to ti	ne cause of deat	h?
rds	w requires been sign should be	ed by	End Stage F	Renal Diseo	de						1[Yes 2	2 □ No 3	☐ Prob	ably 4 Donk	nown
Secc	ie law re has bev ge 2 sho	Completed									24a. Wa	as an topsy rformed?	pri	or to co	psy findings ava	ilable e of
tal	an: The ifficate or, pag		25. Was case referred to medic	al					26 Place	of Death	1 Yes	2 2 N		ath?]Yes	2 No	
Z	hysicia his cert I direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie			er: 4□ Nu		me 5□Re		6 □Other	(Specif	y)	
ouo	ding P. After t	ion:	27. Manner of Death 1 Natural 5 Pend		e of Injury nth, Day Year)	28b. Time o Injury	of 28	8c. Injury Work 1 □ `	yat ⟨? Yes 2□	1	28d. Describ	e how inji	ary occurred			
Division or Vital Records,	Atten er deat rector: by the	Certification:	3 Suicide 6 □ Could	not be 28e. Place	e of injury - At h		reet, factory,					(Street a		or Rura	I Route Number	r,
ō	pital or urs aft eral Di		29a, Certifier 1 Certify	ing Physician: To th			th occurred	at the tin	ne date ar	nd place				10r 20 0	tated	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		al Examiner: On the												
	Voithin To the comp	Me	29b. Signature and title of certifi	P L MAS			29c.		6100	7			ate signed (Day, Year) 2007	
•	ſ		30. Name and address of perso	-	use of death (Iter	n 23a) (Tvne	Print)				0.1			A	002	
	P		KENNETH KITAI	NDAGLE, MD	831 E	. Univers		id Su	lite 29	5	Pilver d	ipring	MD	20	403	
	Sta Registr		31. Date filed (Month, Day, Yea	r) 32.	Registrar's Sign	ature	land.									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a,25,27,28a-f perime 8874-121/11/07dhb Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** LBers 20 2007 /Medical 4b Oity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTE 2 DALTIMERO Masical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 **X**M 2 □ F 220-64-3307 Yrs. MARYLAND Director DECEMBER 5, 1961 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show r 28a-f show notified at 1 Yes 2 No NIA BALTIMORE Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or ? must be n RAYSHIRD 2123 2908 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. filed within 72 hours after 1 Mever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LONGSHOREMAN ATC LOGISTICS 12TH GRADE nd 2 should be filed walth and Mental Hygier 27 Is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SR. ALBERT D.D. MORGAN ADAGRADE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau PATRICIA HAMMOND (FIANCEE) RAYSHIRD ROAD, BALTIMORE, MD 2908 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-05-2007 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 21. Signature of Funeral Service Licensee JOSEPH H. BRUSN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 Gramo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CERTIFICATION APPROVED BY MEJICAL EXAMINER **Physician** to (or as a consequence of): 05007 /Medical Due to (or as a consequ Examiner PSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ezitodi715 The law requires that the death certificate be execute burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No Division or Vital Records, P.O. been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given n Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown SRAIN 1 □ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performe Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28d Describe how injury occurred Subject driver 27. Manner of Death 28b. Time of 28c. Injury at Work? of a car that 5 ☐ Pending investigation 1:29 a M 1 ☐ Yes 2 ☐ N n 24 hours after death. he Funeral Director; A pletely filled in by the fi 2X Accident struck an SUV 3☐ Suicide 6 ☐ Could not be At home, farm, street, factory, office e of injury determined (Specify) Town, State) 2300 Block, Tacoma Street 4 ☐ Homicide 📭 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fun

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30142 0 30. Name and address of person who completed of death (It 0 31. Date filed (Month, Pay, Year DEC 1 1 200) Year) State Registrar

			1 - For Anend Items 2	State of Mary 3a,30 per dr/v	/land / Depa r,₈874,12 /J	artment of l	lealth a <i>Death</i>	nd Mental	Hygier Reg. I	ne 200	7 3979
d	Physic	ian	1. Decedent's Name (First, Middle, La.	,				2. Date of		Day Y	3. Time of Death
	/Medi		JOSEPH LEO MILLS					NOV	/	29 20	07 9:45P
•	Exami	ner	4a. Facility Name (If not institution, give	,		4b. City, Town, o			1	4c. County of	
		7	7410 BROOKWOOD A 5. Social Security Number 6. S		n yrs. last birthday)	BALTIMOF If Under 1 Year			of Birth	BALTI	MORE D. Birthplace <i>(State or Forei</i>)
	Funeral Director		705~10~6604	ex 121 M 2□F 7. Age (1	Yrs.	Months Days	Hours	Min. (Monti	10^{ay} , 10^{ay}	911	Country) Maryland
7	5		Usual Residence of Decedent						,_		
relyne	show	_	10a. State 10b. County		Oc. City, Town or Lo	cation					10d. Inside City Limit
Mod	28a-f	ecto	Maryland Baltimor	re	Baltir	nore Cour	ity		1.0	000	
with	a or i	ä	10e. Street and Number 7410 Brookwood A	lvenue		10f. Zip Code	21236	3	10g. (Citizen of Wh	at Country?
filed within 72 hours after death with the Maryland	incomming to more and upon the way yan tall Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of H f Yes, specify Cub			r No-		American Indian,
after	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes ※ XXNo If Yes, Give	i	If Yes, specify Cub 1 □ Yes 2 ⊠ No		, Puerto Rican, etc	.)		White, etc. White
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ad bl	marked o	To B	James Leo Mills			,	Αç	gatha Rut	h Hop	ор	
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bue	Health tem 27 I		Evelyn G. Mills (V) Brookwo	od Ave				
ermit Pages 1 and 2 should be filed within 72 hours af	or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State		natory or other pla	· · · · · ·	Date			ty or Town, State
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nerm	pornit. 1 ages 1 and Department of Heal Important: If item 2 any Injury or other gonce.		21. Signature of Funeral Service Licer	see	2	assann F 401 Bela	uneral ir Rd.	l Home . Baltimo	re, N	Md. 212	236
	hysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line.	death. Do not ent	er the mode of dyin	ng, such as c	cardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
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cian:	is certificate h director, page	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check o			
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l or Attending Phys	ath. rr: After ne funera	ertification:	27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation	1	ear) 28b. Time of Injury	Wor	ryat k? Yes 2∐N		ribe how in	njury occurred	l
ō	s after death II Director: ed in by the	ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Locati City o	on (Street r Town, St	and Number ate)	or Rural Route Number,
e Hospital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	ysician: To the best of mainer: On the basis of exand manner stated	amination and/or in	occurred at the tivestigation, in my	me, date and opinion, deat	d place, and due to h occurred at the t	the cause ime, date a	e(s) and mann and place, an	ner as stated. d due to the cause(s)
Toth	within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number	Y		1 1	Month, Day, Year)
1	(15)		30. Name and address of person who				700-1	O	1	1130/0	
1	10	4	Howard Goldman, M.D.,	-	-	Strite 304,	Baltimo	re,MD			
	Sta	ite	31. Date filed (Month, Day, Year)	34 Registrar's	Signature	while I					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e per fh. 88/4, 12/12/0/dhb

Amend Items 28h, i per me, 88/4, 12/12/0/dhb

ar 25, 28de Certificate of Death

Reg. No. 2007 Reg. No. 20 28de 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Wovember 23, 2001 **Physician** WILLIAM E. MASON /Medical 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Ba 4c. County of Death 4b. City. Town, or Location of Death Examiner Sinai Baltimore Baltimore BALTIMORE CITY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. XXM 2 F Yrs. Director 215-14-0342 84 18, 1923 Maryland June Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ehow item 27 ie marked other than "natural", or items 23a or 28a-f ebov other treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√XNo Directo Maryland Baltimore Baltimore County 10e. Street and Number **Pot** 10g. Citizen of What Country? 10f. Zip Code 2525 Pets Spring Rd. Apt. K-506 **USA** 21093 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: WW 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 🙎 Married 1 ☐ Yes 🎗 😾 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C. & P. Telephone Co. 12 yrs. N/A Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 12 should be t and Mental F ❷ William R. Mason Mary Catherine McElroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Edythe K. Mason (wife) 2525 Pot Spring Rd. Timonium, Md. 21093 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If its any injury or of once. Metro Crematory, Inc. Nov. 26, 2007 Baltimore, M 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6.3. Baltimore, Md. 21236 Jasseln Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subdural Hematoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Herniation em Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Motor Crazh that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ -enslon 1 🗌 Yes 2**V**No 3 ☐ Probably 4 ☐Unknown Completed ibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed certificate 1 Yes 25 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ After thi 28d. Describe how injury occurred Subject fell 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No investigation -22-07 9:30p 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1522 Charmuth Rd. 4 - Homicide 0 Driveway home Timonium, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5493 Nam November 28, 2007 ogowy 1241 30. Name and dress of person who complete use of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE 4070A 31. Date filed (Month) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/17 18 per FH (874 12/19/07 WS)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2007 12 5:00 PM 07 <u>Jessie A. Monks</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) Examiner Timonium, Maryland
Under 1 Year | If Under 24 Ars. | 8. D.
onths | Days | Hours | Min. | (A Baltimore Stella Maris Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs 1 □ M 2 🖫 F Yrs Director 07/24/1910 Maryland 213-20-1636 97 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 → No r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified Director MD Baltimore Kingsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 5 Bluestone Court 21087 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Homemaker</u> Own Home 8 18. Mcther's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MacKenzie Margaret Corrat MacKenzie ဂ္ William McKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 Is m any Injury or other traum 21087 5 Bluestone Court - Kingsville, Maryland Ruth Snyder (daughter) timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Air Memorial Gdns: 12/12/2007 Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee Bal any Ir _21087 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Wroke **Physician** disease or condition resulting in death) /Medical Bue to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2전 No 24a. Was an autopsy performed?
Yes 2 X No has 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 TYes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P Division or funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier NI IN e cemben MINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.DTIMONIUM, MD 21093 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

5:00

DECEMBER

JESSIE MONKS

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			1 - For Amend Item 2	State of M	laryland /4,12/1 2/	(Ole 20 (Ole 20)	itment of F	lealth and Me Death	ental Hyg	giene Reg. No.	007	39799
			1. Decedent's Name (First, Middle, L	- 1	10.4		(/		2. Date of Dea	ath	V	3. Time of Death
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	/Medic		4a. Fecility Name (If not institution, g)		4b. City, Town, o	r Location of Death	1	4c. Co	unty of Deet/f	
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	and w		10a. State 10b. County		10c. City, T	own or Lo	cation				1	Od. Inside City Limits
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	r de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Decedent of H f Yes, specify Cuba	lispanic Drigin? (Spec an, Mexican, Puerto F	Rican, etc.)	14.	Bleck, White,	
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nd	be fill H doth	Be	17. Father's Name (First, Middle, Las	it)				18. Mother's Name	(FIFST, MIDDIO,	Maidell 30	maine)	
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a	and and is m		19a. Informant's Name/Relationship			19b. Maitir	g Address (Street	and Number or Rural	Route Number	er, City or To	own, State, Zip	Code)
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with 18 23; se not		11. Marital Status	12. Was Decedent	Ever in U.		ecedent of Hisp					nerican Indian, Black,	٦
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after o	by F	3 Widowed 4 Divorced	Yes, Give Year		1 Y	es 2 X No	specify:				White	
ours	ğ[15. Decedent's Education (Specify only	highest grade com	pleted)	16a. Decedent's	Usual Occupation of working life. I	on (Give kind	of work done retired)	16b.	Kind of Busines	ss/Industry	-
6 n 72 h an "n	jet	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		Fabrio			Di	etric	Industrie	
5-0036 iled within 72 Hygiene. I other than	Completed	12th			Mecar			(F) -1 -1 f			Industrie	긔
Hyg d oth		17. Father's Name (First, Middle, Last)	~			18		ame (First, Mic		n Surname)		-
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2, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	H	20a. Method of Disposition	JI . / I	20b.	Place of Disposition	n (Name of cem	etery,	Date			or Town, State	ᅥ
MOFe, Pages I ar		1 Burial 2 X Cremation 3	Removal from Sta	Ba	crematory or other	^{rplace)} Cremato	orv .	12/11	/07 E	Baltimo	ore MD	1
ti. Pagtimens		4 Donation 5 Other Specify:	-			ne and Address						ᅥ
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	Consultation of the state of th	e h							alto. MD ex 21221	
Physician	-	23a. Part I. Enter the disease, or complice	cations that caused	he death	. Do not enter the	nnelly mode of dying, s	such as cardia	ac or respirate	ory arrest, si	hock, or heart	Approximate Interva	
> /Medical		failure. List only one cause on each	h line.								Between Onset and Death	d
xaminer			fultiple Stab W ue to (or as a conse		of):							\dashv
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recuted and ransit		events resulting in death) Last d.	20 (0) 20 2 2									
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Box 68760, e death certificate be the attending physicied for use as the buri	sician/Med	IF FEMALE:	23c. If yes, outcor	ne of pred	nancy				2	3d. Date of deli	very	-
Box 68760, e death certificate be the attending physic ed for use as the burned for use	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth		-	death 3	Ectopic pre	egnancy	1	Month	Day Year	
ath ce attencor use	sici	1 Yes 2 No 9 Unknown	4 Pregnant at	time of de	eath 5 Othe	r (Specify)			_			
the de	Phy	Part II. Other significant conditions	9 Unknown	h but not r	resulting in the un	tertving cause di	iven in Part I.	23e	. Did tobaco	o use contribute	e to the cause of death?	-
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OFC aw re nas be	ble							-	autopsy performed		to completion of cause of h?	i
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of Vital Recing Physician: The After this certificate uneral director, page	Be	25. Was case referred to medical examiner?	ospital:				of Death (Che					_
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ivisior or Attend after death Director:	äţ	2 Accident Pending Investigation	n		(ation /Stree	t and Number o	r Rural Route Number, Ci	ity
Division of Vital Records, pital or Attending Physician: The law requirents after death. real Director: After this certificate has been silled in by the funeral director, page 2 should the	Certification:	3 Suicide 6 Could not b determined	e (Specify) Ba		ome, farm, street,	lactory, office bi	ullullig, etc.	or T	own, State)			·y
D Hospital 24 hours Funeral		4 M Homicide				d at the time do	to and nices					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only one) 2 Medical Examiner:	On the basis of exa	y knowled mination	age, death occurre and/or investigation	n, in myopinion,	, death occurr	red at the time	e, date and	place, and due	to the cause(s)	
To the within.	led Med	29b. Signature and title of certifier	and manner stated.			29c. License					(Month, Day, Year)	_
		Doma MOIN	centin)		O.C.N			D	ecember 9,	2007	
	ļ				n 23a)							
4		 Name and address of person who con Donna M. Vincenti, MD 	ompleted cause of d Assistant Medi			Penn Street,	Baltimore	e, MD 2120	01			
St	ate	31. Date filed (Month, Day, Year)	1-	r's Signat		-						
Regist		DEC 1 2 2007	House	, J.	Sperke	<i>P</i>						
DHMH 17 Rev 1/2	001	5202			OPIGINAL							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 2007° Hope Marston 8:15aM December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1317 Decatur Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year 12/6/1926 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 216-20-7666 81 1 □ M 2 🕱 F Yrs MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Me Iteal Examiner must be notified at anone. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits **Baltimore** MD 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1317 Decatur Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😾 No White Specify: <u>ک</u> 3 ☐ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Industry Rate Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Coleman Joseph Burns ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Starr H. Brigerman / Daughter 135 Hull Street, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12/13/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vietor P. Doda Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): DASTY Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ HO Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 Probably 4 Unknown Be Completed UCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 21 LONGESTIVE 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 25 No Hospital: 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred T Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and Box 68760, Division or Vital Records, P.O. To the Hospital within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

Certification: To 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLACE

DECEMBER 11, 2007

State Registrar

31. Date filed (Month, Day,

Year) DEC 1

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert WMallette Day **Physician** 9:55PM DECEMBER 8 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL OF BALTIMORE BACTIMORE SINAI CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□F Hours Virginia 226.52.8444 65 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits Baltimore 1 Yes 2 □ No MD Directo 10e. Street and Number 10g. Citizen of What Country? u.sA 2/2/ Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) W.R. Grace aborer 18, Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATO CELLULAR CARCINOMA 2 YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 3 Probably 4 Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 DIASEES MELLITUS autopsy performed? res 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? a No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: this within 24 hours after death. To the Funeral Director: After

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

and Mental Hygiene

is marked

Department of Health Important: If Item 27

Physician

/Medical

Examiner

Baltimore,

ROBERTY MACLE

£

KNOWN Maryland

> 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 8, 2007 RES - 000

> > BALTIMORE

OF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENGUPTA HOSP ITAL MA SINAL

31. Date filed (Month, Day, Year)

32. Registrar's Signature Statute.

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	eartment of Health and Mertificate of Death		ene 007	39803
	Dhomisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Dav Year	3. Time of Death
	Physicia /Medic		Shirley May Minter		December	r 8 2007	3:20 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 113 - 14th Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F 72 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) Aug. 25	Year) 9. Birthpi Coun , 1935 Mary	lace (State or Foreign try) Land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			0d. Inside City Limits
	Maryi -f sho	tor	Maryland Anne Arundel Baltimo	ore			1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	ath wil		304 West Arundel Road	21225		U.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28e-f show amy injury or other treumstic event, the Medical Examinar must be notified at another.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 🖰 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 🖸 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
ς Ω	72 ho	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16	6b. Kind of Business/Inc	lustry
72	within ene.	Completed	College (1 Ass 5)	DO NOT use retired) emaker		Own Ho	me
ğ	Hygie other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	laiden Sumame)	
<u>Ja</u>	2 should be to and Mentel I is marked of reumatic eve	ToE	Norman White		Hagner		
Maryland 21215-0036	and 2 sho selth and n 27 is m			ling Address (Street and Number or Run - 14th Avenue B		City or Town, State, Zip , Maryland	
Baltimore,	of Herrittem		1 d Burial 2 I Cremation 3 I Hemoval from State	ematory or other place)		Oc. Location - City or To	
Ē.	trent of trant: If it		4 Donation 5 Other (Specify) Glen Hav			Glen Burnie	
Ba	Depar Impor any in		· NA	001 Ritchie Highwa	y Baltin		and 21225
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	rialog failu	re		
	Examiner		Sequentially list conditions b. End Stage	chunic o	between	eline	
	\$ W \$	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Produce marie	Deline	~-	
	ificate be executed physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	, 00 1100 1300			
8760,	ysicler	call	d				
9	ing ph	Medi	IF FEMALE:				
Вох	eath ce attend for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Day Year
Ö.	t the d by the eched	hysi	1 ☐ Yes 2 ②No 9 ☐ Unknown				
rds, P.	quires thet the death certific n signed by the attending t uld be deteched for use as	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to ths s 2. 2. No 3. □ Prob	ne cause of death?
Division of Vital Records,	The law requires thet the death certificate be executed site has been signed by the attending physicien and a signed be deteched for use as the burial-transit	Completed			24a. Was an autopsy perform	ed? death?	psy findings available mpletion of cause of
ita	ien:]	BeC	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one		2010
> <	hysic his ce	To	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati			nce 6 XOther (Specif	Son's Home
n C	ding P	ion:	27. Manner of Death 1 ⊠Natural 5 □ Pending (Month, Day Year) □ Accident investigation (Month, Day Year)		28d. Describe how	w injury occurred	
ivisio	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funers! Director: After this certificete has completely filled in by the funers! director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rura , State)	il Route Number,
Ω	To the Hospital of within 24 hours af To the Funers! D completely filled in		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the car	use(s) and manner as s	tated.
	n 24 h n 24 h he Fur pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur			
	Vith To t	Σ	29b. Signature and title of certifier	29c. License number	2 29	od. Date signed (Month,	
F	. 1		30. Name and address of person who completed cause of death (Item 23a) (Typ	e Print)		1-111/20	
	0 j		Dr. L. Seenivasan Harbor Hospi	ital Gruehn Bldg.	Suite 10	8 Balto., M	D. 21225
	Sta Regist		31. Date filed (Month, Day, Year) DEC 1 2 2007 32. Registrar's Signature	parle?			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09439 State of Maryland / Department of Health and Mental Hygiene Kathleen Quinn Marlatt 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 5, 2007 1322 hrs Medical Examine Kathleen Quinn Marlatt 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Ellicott City 4345 Centennial Lane 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Country) Hours Days 7/4/1940 Director 217.38.1663 67 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Yes 2 No Ellicott City or items 23a or 28a-f show must be notified at once. Howard MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 4345 Centennial Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 y Married 0. Yes specify: White Yes, Give Year Yes 2 x No specify: Divorced Widowed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked offer than "natural"; injury or other traumatic event, the Medical Examiner. 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sales Associate Retail 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Ouinn William Schatz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 2016 Eldersburg, MD 21784 Advisory Ct. Mr. Tom Marlatt 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Louis Cametery 1 Burial 2 Cremation 12/10/07 Clarksvilla, MD Denation 5 Other Specify 22. Name and Address of Facility lack Funeral ure of Furjeral Service License MD 21043 3871 Old Columbia Pike, Part I. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only on cause on each line 'Medical a Multiple sclerosis Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

aminer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause

(Disease or injury that initiated

events resulting in death) Last

29b. Signature and title of certifier

Pamela E. Southall, MD 31. Date filed (Month Pax, Year)

Examine and transit Physician/Medical physician the burial -Box 68760, Division of Vital Records, P.O. ģ Completed certificate has been ector, page 2 should To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: After this certific completely filled in by the funeral director, t Be Certification: To Director: d in by the f

X UNPENDED	#23a.PII.27.28a-	f. perME,g876	, 2/1/08 TT				
IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de 9 Unknown	2 Fetal death			23d. Date of d Month	Day	Year
Part II. Other significant conditions of Asphyxia	ontributing to death but not re	esulting in the underlyin	g cause given in Part I.	3.14	2 No 3	Probably 4 Vere autopsy find rior to completion eath?	Unknown ings available
25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Check	1 ✓ Yes 2 k only one) sing Home 5 R	No 1 esidence 6 ₩	Other: Scene	2 No
27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At h	28b. Time of Injury Fnd 1:10 pm ome, farm, street, factor	28c. Injury at Work? 1 Yes 2 X No ry, office building, etc.	28d. Describe ho dependent detached t 28f. Location (str 4345 Cente	subject racheost	found with	Number, City
29a. Certifier 1 Certifying Physicial	n: To the best of my knowled On the basis of examination a	ge, death occurred at the	ne time, date and place, ar my opinion, death occurred	nd due to the cause I at the time, date ar	s) and manner nd place, and d	as stated. ue to the cause(s	5)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Medical

State

Registra

Assistant Medical Examiner

32. R

2007

29d. Date signed (Month, Day, Year)

December 6, 2007

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician nia 4, 2007 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 44 212-88-8266 Oct. 28, 1963 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits with the Marylar show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director <u> Maryland Anne Arundel</u> Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Oak Grove Road 21090 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by Specify: White Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Weekly Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Vernon L. Neilson Gerber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon L. Neilson (Father) 502 Oak Grove Rd., Linthicum, MD 21090 permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/8/07 Baltimore, Maryland 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licensi 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a therosclerosis OFONATU earc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes ☑ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No te has b 24a. Was an Was autopsy performed? 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 2 ER/Outpatient 3 □ DOA ျ 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. or Attend after death. 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of conflier 29c. License number 29d. Date signed (Month, Day, Year) WD D51018

5

State Registrar

30. Name and addre

as Pinto, MD 3421 R Registrar's Signature

Benson Ave.

Baltimore, MD 21227

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item damperador De874 ment 12 Health and Mental Hygiene

			1 - State On Waryfand Department of He Registrar Certificate of L		Reg. Nor	2007	30807
	Physicia	an	Decedent's Name (First, Middle, Last) CELESTINE NELSON	2. Date o Month	Day		3: Time of Death
* - * -	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or		. 07	2007 County of Death	22:23 ^M
F	Examin	er	5314 LIBERTY HEIGHTS AVENUE BALTI	MORE CITY		N/A	
	Funeral Director		5. Social Security Number 217-09-6522 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Yrs. 9 2 Yrs. If Under 1 Year Months Days	Hours Min. 8. Date o	f Birth , <i>Day</i> , <i>Year)</i> 09/19	Cour	place (State or Foreign htry) RGINIA
	/land ow at		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			1	0d. Inside City Limits
	e Mary 3a-f sh tified	ctor	MD N/A BALTIMORE CI	TY			Y Yes 2 No
	th with th 23a or 24 ust be no	ral Director	10e. Street and Number 5313 LIBERTY HEIGHTS AVENUE	21207		zen of What Cour	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 XNo	spanic Origin? (Specify Yes on n, Mexican, Puerto Rican, etc Specify:)		etc. BLACK
2-0	"natu "natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done differ DO NOT user etitred.)	lurina most of workina	16b. Kir	nd of Business/In	dustry
212	yiene. r than the M	omo	Flomenton/Secondary (0.12) College (1-4or 5+)	TECHNICIAN		MEDIC	'AL
land ;	ld be filed lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) BURCHES ROBERTSON	18. Mother's Name (First, Mi HENRIETTA			
Mary	and 2 should satth and Mer n 27 Is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) GRAND DAUGHTER 1306 SADD	and Number or Rural Route N			21200
Baltimore, Maryland 21215-0036	Pages 1 a ment of Hea ant: If item ury or othe		20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATL MEM. P.	Date ARK 12/15/0	1	cation - City or To	
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service Licensee 22. Name and Addres	ss of Facility HOWEL ERTY HEIGHT		ERAL HO	
68760,	Physician /Medical Examiner b b b b b b b b b b b b b b b b b b b	cal Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying stricts or heart failure. List only one cause on each line. Imme fate ause (Final disease condition) resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unleaded or highly that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death
P.O. Box 68	ath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		_	23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e.			the cause of death? bably 4 Unknown
Division or Vital Records,	Physician: The law req this certificate has beer al director, page 2 shou	Completed		24a.	Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
/ita	Physician: r this certifica	Be C	25. Was case referred to medical examiner? Hospital: 4 The properties and TER Contractions of TER Contrac	26. Place of Death (Check of			
nor	ing Physi Affer this c Ineral dire	on: To	27. Manner of Death 18. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Word Injury 28b. Time of Injury Word 28c. Injury Wo	y at 28d. Desc	ribe how injur		ify)
Divisio	or Attending of the death. Director: After in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation M 1 ☐		ion (Street an or Town, State		ral Route Number,
J	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical Ce	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, death occurred at the fir and majority states of examination and/or investigation, in my content of the pasts of examination and/or investigation, in my content of the pasts of examination and/or investigation, in my content of the pasts of examination and/or investigation, in my content of the pasts of examination and/or investigation.	me, date and place, and due to opinion, death occurred at the	o the cause(s time, date and) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier 29c. Licens	e number	29d. Da	te signed (Month	, Day, Year)
	25		D43	2736	12	1-11-0	7
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). AUMAN AKKAGMD 7600 DSLET	or #411 To	wson	mix	21264
ľ		ate	31. Date filed (Month, Day, Year) 2007 2. Registrar's Signature	1, - 1,, 10		, 11	212-1
	Regist	rar	DEO I - COO!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 50 PM PUMPITREY 2007 CHARLES 12 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD WINTY GENFRIM armaia tonago HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 83 Yrs. 212.36.8758 Director April 17, 1924 Maryland Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A 3731 Valerie Carol Court Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 DNo Specify. <u>Ş</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Howard County Gov't. Clerk of Circuit Court permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Brown Charles A. Pumphrey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3731 Valerie Carol Court, Ellicott City, Maryland 21042 Ms. Dorothy Pumphrey Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 ☐ Removal from State 12/09/07 Sykesville, Maryland All County Cremation Services, Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO053 W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NWTE RESPIRATING /Medical Due to (or as a consequence of): **Examiner** PREDIMEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner non smari COLC Way CANCER Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for L Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ARKERY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autonsv performe Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

32 Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON MOTOMAYM. U

Registrar

13724 LITTLE PATURENT PLANY

2007

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Councia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene State of Jean Maryland / Department of Health and Mental Hygiene Registrar 39809 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Ro Girson Month **Physician** 7.50AM 2001 de November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** GOOD SAMARITAN BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 75 231-36-7238 Yrs Director 04-23-1932 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n 21239 USA 1200 SHERIDAN AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items dica Examiner mu Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: BLACK 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL STEEL WORKER marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : 1 and 2 should be fill Health and Mental H tem 27 Is marked ott Be CORNELIUS TURNER JIMMIE ROBINSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 SHERIDAN AVE; BALTIMORE, MD 21239 ROSETTA ROBINSON/WIFE other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If II any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 12-06-07 EMPORTIA, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 a Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ess thou **Physician** monary disease or condition resulting in death) /Medical Due to (or as a consequence of): 10 der Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran MEDICAL EXAMINER Due to (or as a consequence of): 68760, physician Physician/Medical CERTIFIC) the as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? should be d Completed by 1 Yes 2 No 3 Probably 4 VInknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? this certificate 2M/No 2 **2** No Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) 1 Yes 2 2 Ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation atura! 2 Accident 3 Suicide 1 ☐ Yes 2 XNo death. 10/20/2007 | Unknown M Subject fell down stairs filled in by the after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 12(0 Sheridan 4 Homicide determined Ave., Baltimore, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital within 24 hours a to the Funeral I 29a. Certifier mpletely (Check only one) 29d. Date signed (Month, Day, Year) 2007 WOVEWILL 30^(A) 29c. License number, D 3066 / 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year) 7 0

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To

			State of Maryla				d Mental Hyg	giene	
			1 - State Registrar	Cei	rtificate of	Death		Reg. No.2 1 7	39810
Ĺ	Physicia	an	1. Decedent's Name (First, Middle, Last)	1.1			2. Date of Dea Month	Day Year	3. Time of Death 7 1:40 P. M
er.	/Medic	al	Diana Jane Rathe 4a. Facility Name (If not institution, give street and number)	11	4b. City, Town, o	r Location of De	Decemb	er 7, 200	*
) 	Examin	er	Anne Arundel Medical Center		Annapo		5441	Anne A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Birth		rthplace (State or Foreign country)
	Director		214 38 7896 1 M 2 AF 66	Yrs.	Months Buye	, nounc	12/18/		est ['] Virginia
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation		-1-		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Anne Arundel	Pasaden	ıa				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	country?
	s 23a		7853 Centergate Court	10 10		122) (O===if= V=====N=	U.S.A.	orican Indian
_	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in I Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No			an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	Black, Wh	
036	ral", or	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
2	72 hc 'natul dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b. Kind of Busines	s/Industry
121	within ene. than '	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	1	bo nor use retired tress	a)		Food	
ק ס	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. In marked other than "natural", or ftems 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's I	Name (First, Middle,	Maiden Surname)	
<u>Ian</u>	ould be Mental arked o atic eve	To B	Fred Helmick			Ver	a Miller		
Maryland 21215-0036	2 sho and I s ma		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State,	
	1 and Health em 27 ther tr		Timothy Rathell / Son 20a. Method of Disposition 20b.		Centerga		t Pas	adena, Mar	yland 21122 or Town, State
nor	Pages nent of I int: If Ite		1 Burial 2 La Cremation 3 Removal from State		osition (Name of matory or other place		2/13/2007	•	, Maryland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic once.		21. Signature of Fineral Service Licensee		Crematory 2. Name and Addre	on of Engility	· · · · · · · · · · · · · · · · · · ·	eral Servi	-
ñ	Der any		NAT	40	001 Ritch	ie High	way Balt	imore, Mar	yland 21225
			23a. Part1. Enter the diseas. or complications that caused the des					rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	stive	hear	tai	lure		2 months
	/Medical Examiner		Due to (or as I conse	quence of):					
		Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	quence of:					
	ocuted nd transit	Examiner	that initiated events c.						
60,	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	EX	resulting in death) Last Due to (or as a conse	quence of):					
28760	icate l physics the k	dical	d						
Box	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf preg 23b. Was decedent pregnant		75-4			23d. Date of d	elivery
	death	sicia	in the past 12 pronths? 1 Live birth 2 Fe		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Month	Day Year
о. О	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not re	oulting in the u	indorfujna nauco di	on in Part I	23a Did to	phacen use contribute	to the cause of death?
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	The lar te has age 2	Completed					— autor	prior to death' 2 No 1 1 Ye	completion of cause of
VItal		Be C	25. Was case referred to medical examiner?			26. Place of	Death (Check only o		2 110
	Physician: The lavithis certificate has al director, page 2	To	1 ☐ Yes 2 No Hospital: 1 Inpatient 2[ER/Outpatier		4 LI Nursir		dence 6 □Other (S _k	pecify)
Ü U	ng l	ion:	27. Manner of Death SAlatural 5 ☐ Pending (Month, Day Year) Contact investigation (Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ∣Yes 2 ∐ No	28d. Describe I	now injury occurred	
Division or	Attended death	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At	home, farm, st			28f. Location (S	Street and Number or	Rural Route Number,
5	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Spec	ony)			City or Tov	vn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only) 2 Medical Examiner: On the basis of examiner:						
	thin 24	Medical	one) and manner stated. 29b. Signature and title of certifier 1		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
	F & F 8		I and Dever	· MO					
•	6		30. Name and address of person who completed cause of death (ite		Print)	4		- /	2007 ton, mD2111
	Ψ			22 5	I De	tens	e Huy	, Crox	10m, m/2/110
	Sta Registi		31. Date filed (Month, Day, Year) 32-Registrar's Sig	nature			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

07-09517 John Romanick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 39811

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			-	Social Security N		6. Sex		7. Age (In	yrs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of Birt	th(MM/DD/YY	Fore	Birthplace (State or eign	
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	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	yen,		9a. Informant's N					1	9b. Mailin	g Address	(Street	t and Num	ber or R	ural Route Nu	ımber, City or	Town, S	State, Zip Code)	
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	and 2 lealth tem 2			0a. Method of D	isposition				20b. Place	e of Dispos	sition (Nam her place)	e of cen	netery,		Date	20c. Loca	tion - Cit	ly or rown, State	1
	Baltimore, MD 21215-UU36 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is nameded other han "natural", are items 64a or 60a-64 sho	other	ч.		Cremat		Removal	from State	payvi	ew Cr	emat	ory		12/	11/07	Balti	more	, MU	
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1	¬hysicia		23a. Part + Enter the leease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only the cause on each line.												Between Onset Death	t and			
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$\sqrt{}$	ted 1			events resulting	in death) La	d.												100	
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	Division of Vital Records, tal or Attending Physician: The law require a part details and the configuration of the	d in by	Certification:	3 🗸 Suicide		Could not determine	be	ecify) Sind				,			or Tov 3200 Pine	vn, State) e Orcharch I	ane, E	Ilicott City, MD	
	D sspital hours	y fille		4 Homici 29a. Certifier	de		, , ,				curred at t	he time,	date and	place, a	nd due to the	cause(s) and	manner	as stated.	
	Division To the Hospital or Attend within 24 hours after death	To the Funeral Director: completely filled in by the	Medical	(Check only one) 2	✓ Medical	Examine	r:On the b	asis of exan	nination and	d/or invest	igation, iii	пу орпп	ion, death		d at the time,				
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	th.			30. Name and	address of p	erson who	completed	cause of d	eath (Item 2	23a)	. Don- 1	Stroot	Raltim	ore MI	D 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day 8 1. Decedent's Name (First, Middle, Last) **Physician** 1753 PM JR December umas 2007 add /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore MD Maryland niversity /ear | If Under 24 Hrs. Birthplace (State or Foreign Country) Under 1 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Days Months Hours Min Director NEW Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No þ 3 ☐ Widowed 4 ☒ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GORDON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RADD ပ 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STANL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City Burnal 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of 21 Signature of Funeral Service Licensee MD 2121 23a lant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inn ediate Cause (Final day **Physician** rainstem nemory had disease or condition sulting in death) /Medical Due to (or as a consequence of): Examiner raumaho THE REAL PROPERTY OF MACHINE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the aftending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached 9□Unknown 9 Unknown þ signed ! 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 2 No certificate Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 2153 PM 1 ☐ Natural 2 ☑ Accident 2 Location (Street and Number or Rural Route Number, City or Touth, State) Dec 6, 2007 2153 pm 10

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 5 Pending investigation 1 ☐ Yes 2 ☑ No Struck by car 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tephanie 30. Name and address f person who completed cause of death (Item 23a) (Type, Print) 2 South Stree 31. Date filed (Month, Day, Year) trar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state & Marylan 1970 Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** NANCY 2:50 p.^M SLECHTER YVONE DECEMBER 9 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FOREST HILL HEALTH & REHABILITATION HARFORD FOREST HILL 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 Maryland Director 215-34-5625 Usual Residence of Decedent 70 with the Maryland 10c. City, Town or Location 10d. Inside City Limits works 10a. State 10b. County at r 28a-f sh notified 1 ☐ Yes 2 1 No Director MD Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or adical Examiner must be n U.S.A. 21131 14006 Sunnybrook Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant. If item 27 Is marked other than "natural", or items 23, ant. If item 27 Is marked other than "natural", or items 23, ury or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Cafeteria Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Hazel McGowan Andrew Pugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr 852 Main Street - Fawn Grove, Pennsylvania 17321 John A. Hanke (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/11/2007 Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Gi 11750 Belair Road - Kingsville, Maryland 21087 assaln 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of). /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Scertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier D3 2-259 Dec 10 200-) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \Q

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014

Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** December awrence 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Baltinore Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) May 8 1933 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 74 Mary land 216-28-7378 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21060 7647 Turnbrook Drive Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: white Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Manager Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent Stevens Catherine 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7647 Turnbrook Drive Glen Burnie,MD 21060 Ruth Stevens spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removel from State Metro Crematory Inc. 12/11/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Stallings Funeral Home P.A. 3111 Mountain Road Pasadena,MD 21122 Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 🗌 Yes 2 No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA ို 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: filled in by

Registrar

29a. Certifier (Check only

29b. Signature and title of certifier

Dale R. Barnes

31. Date filed (Month, Day, Year)

30. Name and address of person who

5601 Loch Raven Blvd ∌egistrar's Signature

and manner stated.

Emergene

lan

poleted cause of death (Item 23a) (Type, Print)

Balto., MD. 21239

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN TIFM 231 inch. per PTVS C374, 12/12/07 VS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** December 12:10 PM Seabrease EUNICE 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Johns Hopkins Baynew Medical Center 5. Social Security Number 6. Sex 17. Ane //n ure lost high death Battmore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 219-01-8717 87 Director 6-24-1920 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at MD Baltimore 1 ☐ Yes 2 X No Director Rosedale 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? raf", or items 23a or Examiner must be r 1816 Willann Rd 21237 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event the Man Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Eline Bernita Woolford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Hatoff/Daughter 1805 Greencastle Drive Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 12/5/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach / Rosedale Funeral Home 1211 Chesaco Ave Rosedale 21237 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 minotes HYPOXIA /Medical Due to (or as a consequence of): Examiner Agonal Aspiration Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Dysfunction Due to (or as a consequence of): attending physician and for use as the burial-tran The law requires that the death certificate be exec Division or Vital Records, P.O. Box 68760. Sepsis 10 Days Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manper of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Hospital 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

RES-000

M.D. PhD 4940 Eastern Ivenue Bathmore, MD 21224

December 2, 2007

MA, PHD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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VenK

DEC 1 2

31. Date filed (Month, Day, Year)

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			Registrar 1. Decedent's Name (First, Middle, Last)			001	imout	- 01 2	- Cuin		2. Date of Dea		2001	3. Time	of Death
	Physicia		IRENE S. STR	OZYKOWSŁ	Ι						DECEMI	3ER	4,2007	7 4:	35 ₺
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City	Town, or	Location of				County of Deatl		
			402 DUNFIELD C	OURT				JOI	PATO	OWNE			HARFOR	RD	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under Months	r 1 Year Days	If Under 2 Hours	Min.	 Date of Birth (Month, Day 	y, Year)	9. Birth	intry)	te or Foreign
Ł.	Director		Usual Residence of Decedent	74	96	Yrs.					(Month, Day NOV •	10,	1911 1	IEM Y	ORK
	land ow t		10a. State 10b. County		10c. City, Tov	vn or Lo	cation							10d. Inside	City Limits
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92	afte , or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	lo		1 □ Yes		Specify:				Specific		
ë	filed within 72 hours after death with the Maryland Hyglene. rther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d be	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates:	16:	Decen	ient's Usu	al Occupa	tion	_		16h K	W I ind of Business/l	HITE	
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7	with liene. r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	I	NSTR	UCTO)R			WE	STERN E	ELECT	RIC
פ	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Surname)		
<u> a</u>	ould be Mental arked o	To E	STEFAN SLOWAK	IEWICZ					Sī	refa	NIA	N,	/ A		
al	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ	pe. Print)	19	b. Mailin	g Address	(Street a	nd Number	r or Rurai	Route Numbe	er, City o	or Town, State, Z	ip Code)	
altimore, Maryland 21215-0036	and ealth m 27 her tr			ON									ERG, MD.		784
ore Ore	e o = ≥		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	temoval from State	20b. Place o				1		ate		ocation - City or		
≣	tmen tant: tant:		4 Donation 5 ☐ Other (Specify)		HOLY								ALTIMOR	<u> </u>	RYLAN
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License			· 22		Y &	ZEII	ER.	INC. H	UNI	ERAL HO	ME	24224
			23a. Part1. Enter the disease, or compli	cations that caused	the death. Do								rimore,	Approxii	
	Dharatalaa		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	e. /	0.	1		,,		,	,		Interval	Between nd Death
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Box	atten for u	cian	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 ☐ Fetal deat		Ectopic p						Month	Day	Year
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ည္ပ	law re	plet									24a. Was a		24b. Were au	topsy findir	gs available of cause of
ř		Completed										rmed? 241No	death?	2 □ No	n cause of
Vital Records,	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	-			
	Physic rthis or ral dire	2	I les 21 No	lospital: 1 Inpatie					4 ⊔ Nur	rsing Hon			6 ☐Other (Spec	cify)	
Ë	ding P. h. After t	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y <i>Year)</i> 28b.	Time of Injury		28c. Injury Work			8d. Describe h	iow i nju	ry occurred		
S	ttending death. stor After the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	Inv - At home f	arm etra	M eet factor		′es 2□N		8f Location (S	Straat or	nd Number or Ru	val Bouto N	lumbar
Jivision or	for Attendant for death Director in by the	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	aiii, sii	eet, lactor	y, onice		-	City or Tow			nai noute r	iumber,
			29a. Certifier 1 Certifying Phys	l sician: To the best o	of my knowledg	je, death	n occurred	at the tim	ie, date and	d place, a	nd due to the	cause(s	and manner as	stated.	
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner sta	examination a	ind/or in	vestigation	n, in my op	oinion, deat	th occurre	ed at the time,	date an	d place, and due	to the cau	se(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1	,	M	290	c. License	number	0.0		29d. Da	te signed (Monti	n, Day, Yea	7)
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			30. Name and a dress of person who co		eath (Item 23a)	(Туре,	Print)	11 /	1	1-		۸	2109:		- STILL SHIP S
		L IV	31. Date filed (Month, Day, Year)		r's Signature	Tiv	eri	11 1	VI _	70/	AC W	U	大103.	>	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 2 2007		u s signature	Lan	A. A								

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_			1- State of Ma	ryland / Depa <i>Cer</i>	artment of F tificate of		Mental Hy	- 00	07 39817
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Susan Ann Se	idenberg			2. Date of De Month Decemb	Day	3. Time of Death 7:50 A. M
	Examir		4a. Facility Name (If not institution, give street and number) Union Hospital		4b. City, Town, or E1ktor		h	4c. County o	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 XF 7. Age	(In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	rth ay, Year) 1963	9. Birthplace (State or Foreign Country) Maryland
	e Maryland sa-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil	10c. City, Town or Loc Elkton	cation				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	th with th 23a or 24 ust be no	ral Dire	10e. Street and Number 100 Williams Road		10f. Zip Code	921		10g. Citizen of W	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: I fiem Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☒ Not If Yes, Give Year or Dates:	0	Vas Decedent of H f Yes, specify Cuba I □ Yes 2 🛣 No	ispanic Origin? (S nn, Mexican, Puèr Specify:	Specity Yes or No to Rican, etc.)	14. Race Black	- American Indian, k, White, etc. White
21215-0036	I within 72 ho jene. r than "natur the Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 4 Vears	(Give life. E	lent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most of wo ()	rking	16b. Kind of Bus	siness/Industry Home
Maryland 2	uld be filed fental Hyg rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert Johnson				me (First, Middle	, Maiden Surname	
Mary	nd 2 shou alth and N 27 Is mai r traumai		19a. Informant's Name/Relationship (Type. Print) Dr. Jonathan Seidenberg		g Address (Street a			oer, City or Town, S Marylan	
altimore,	Pages 1 a ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Holy Cros	sition (Name of natory or other plac	e)	Date 7/2007	20c. Location - 0	City or Town, State
Balti	permit. Departm Importal any inju		21. Signatur Fune al Service Licenses	22	. Name and Addres	ss of Facility G	once Fur	neral Ser	vice, P.A. aryland 21225
	Physician		23a. Part1. Enter the disease, or complications that caused a shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	he death. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	urrest,	Approximate Interval Between Onset and Death
	ticate be executed by sician and street burial-transit is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_	Hypoxi Spread		ostopei	Cerrer	1 worth 74eers
P.O. Box 68	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
rds, P	juires that signed b ld be deta	by	Part II. Other significant conditions contributing to death but Bilere (please f f)	not resulting in the un	derlying cause give	en in Part I.	23e. Did 1		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
		Completed	Bilereral pleural eft	Ineums+c			24a. Was auto perfo 1 Yes	psy pr prmed? de	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 □ No
Division or Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; t	tion; To Be	27. Manner of Death 1 ♣ Natural 5 Pending (Month, Day)		28c. Injury Work	er: 4 Nursing H		one) dence 6 □Othe how injury occurre	
DIVISI	tal or Atten s after deat al Director ed in by the	Certification;	a □ Cuiside 6 □ Could not be	y - At home, farm, stre (Specify)			28f. Location (City or To	Street and Numbe wn, State)	r or Rural Route Number,
	n 24 hour n 24 hour he Funer pletely filk	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of e and manner state	examination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	iner as stated. nd due to the cause(s)
	Nithi To t	Ž	29b. Signature and title of certifier ask afains		29c. License	5519	0		(Month, Day, Year) er 4. 2007
	10		30. Name and address of person who completed cause of dea Alfred A Piro Mo		*	+ 611		40 2	•
'n	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's		40		, , , ,	-	

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certificate be executed and After

for use as the burial-transit been signed by the attending physician should be detached for use as the burial funeral director, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

Physician

/Medical

Examiner

Funeral

Director

28a-f show la or 28a-f show t be notified at

items 23a

I and 2 should be filed within 72 hours after of teatth and Mental Hygiene. In 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner

item 27 i

Physician /Medical

Pages 1 Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification: To

4 Homicide

29a. Certifiel (Check only one)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe Lyndsey Cox 32. Registrar's Signature 31. Date filed (Month, Day, **ORIGINAL**

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES - 000 29d. Date signed (Month, Day, Year)

Baltimore, MD 21287-9106

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Day Year SWINTON **Physician** JAMES 8.31 A M /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** HOPKINS HOSPITAL BAHIMDRE THE JOHNS N/A Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □**χ**M 2 □ F Director 070-54-4240 Jan 22, 1960 **New York** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mertal Hyglene.
Re Z7 is marked other than "natural", or items 23a or 28a-f show the tran unatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2435 Ridgely Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1978 1 ☐ Yes 2 ☐ No \$ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1999 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of the Army Military 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Evelena Adams Swinton** Joseph Swinton ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2435 Ridgely Street Baltimore, Maryland 21230 Josephine B. Swinton Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ortant: If i 1 □ Buria! 2 □ Cremation 3 ☐ Removal from State 12/15/07 Washington, No.Carolina 4 ☐ Donation 5 ☐ Other (Specify) Pamlico Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Fig. 1. Enter the Jusease, or complications that caused the death. If o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Juliure. List only one cause on each line, ediate Cause (Final ase or condition Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 22 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death. Lest Physician/Medical Examiner Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; attending physician as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □ Yes 2 □ No. detached 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 💥 No 1∐ Yes 20X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1XXNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 XcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MARSHUL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) use of death (Item 23a) (Type, Print)
JOLNS Hopkins Hospital 600 NORTL WOIFE Street Baltimer
MODING SCOT MARSHALL, MD THE Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM/2, perHYS of the alth and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 **Physician** 71(005 /Medical 4a. Facility Name 4c. County of Death Uf not institution, give street and number) 4b. City, Town, or Location of Death Examiner mont 15a l timere. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Funeral last birthday Birthplace (State or Foreign County) 1**X** M 2□ F Days Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Nes 2 No Director 1timore 10e. Street and Num 10f. Zip Code 10g. Citizen of What Country? 21216 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner must once. Funeral Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during life: CQ NOT use refired 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be annie or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore, MD 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NOV K /Medical Due to (or as a con equ nce of): Examiner Sequentially list conditions, flag, leading to kinned at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying code given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed hizophrenia 5000 To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Presidence 6 □Other (Specify) this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) rar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 900 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Baltimore MICIY errale p Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 253-28-3526 1**⊠**M 2□F 25 ECOMOER 30, 1921 GEORGIA Director Usual Residence of Decedent r 28a-f show notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits CITY 1 Yes 2 □ No NIA BALTIMORE Funeral Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 21216 3024 POPLAR TERRACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11 Marital Status Black, White, etc. Armed Forces:

1 Serves 2 No 12-6-42
If Yes, Give
Year or Dates: 16-17-45 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER BETHLEHEM STEEL 5TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event TALLEY HATTIE EDWARD RELL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3024 POPLAR TERRACE, BALTIMORE, MD 21216 GLENDA TALLEY (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 12-14-2007 OWINGS MILLS, MD GARRISON FOREST 4 Donation 5 Other (Specify) 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL HOME
8140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee Part1. En 17 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart GRETIVE **Physician** /Medical Due to (or as a consequence of): Examiner Jewsia 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ona a consequence of) Physician/Medical Examiner burial-trar Due to (or as a consequence of): as IF FEMALE: ise s If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by can 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed P.O. Box 68760 Records, Vital Division or Hospital or Attending

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

physician the, for ed by the a signed by the period of the period of the detection of the detection of the period of page 2 s certificate has this After To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aff completely filled in by the fur

State Registrar

29a. Certifier (Check only one)

Deicel

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UBEROL

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 1 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Ihumas 11:08 PM NOV 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore der 1 Year | If Under 24 Hrs. Maryland Hedical Gents 5. Social Security Number 214-86-8552
Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9 19 196 Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral Was Decedent Ever in U.S. Arrhed Forces?
1 Yes 2 No No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent If Yes, specify 11. Marjtal Status 1 Never Married 2□ Married 3altimore, Maryland 21215-0036 2No 1 TYes Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

HAITOYLSSET Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ nomas 19a. Informant's Name/Relationship (Type. Print) (Nother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barto. let law 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other Date 3 ☐Removal from State 5 ☐ Other (Specify) 4 □ Donation of Funeral Service License Funeral Itome, MO 21216 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypotension **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and use as the burial-tran Due to (or as a consequence of): The law requires that the death certificate be exe-Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 □ Ectopic pregnancy Dav 5 Other (specify) ate has been signed by the a page 2 should be detached to 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠ No 24a. Was an certificate 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 (Impatient Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🛮 Natural 1 TYes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/11/07 Colebala 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. oldo bskiy ama 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 2 Deborah Ann Tibbs 0 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 39 Himore 050 3/DX If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13, 1952 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1 M 2 XF 55 213-62-2076 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Endsleigh Avenue 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
2yrs Elementary/Secondary (0-12) Health Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William W. Grainger Virginia E. Ferrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Tibbs / husband 235 Endsleigh Avenue Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 □Removal from State Bayview Crematory 12/10/07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of): if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

> burial-tran and

physician

þ signed by detail

funeral director, page 2 should

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filled in by

completely

After this

or Attending

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

death.

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Completed

Be

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Certification:

Physician: The law requires that the death certificate be execu

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

Director

Funeral

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Be Completed

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filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu once.

Baltimore,

Sequentially list conditions, if any leading to immediate

al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
ā	Part II Other significant or

examiner? 1 Yes 2 No
27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

D006509L

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Year 0509 M December 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospitzu of Baitimore Boutimore City If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 F Months 219-40-8133 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 211 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: ural", or items 2 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by Blac 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry aylor, Marjorie Elementary/Secondary (0-12) College (1-4or 5+) 12 marase 2 years marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Pages 1 and 2 should be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 356 N. Beaumont 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Important: It any injury o 2/14/07 Baltinure, M trbutus cemetary 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaushn C. Greene fungral 5005 of Funeral Service I 21. Signature aren 728 Liberty Rd. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fallure. List only one cause on each line. 23a. Part1. Enter the seas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physic 2 days sepsis (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 6876 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) sate has been signed by the apage 2 should be detached in ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by disease End stage renau 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Anoxic encephalopathy 24a. Was an autopsy performe insulin dependent diabeter mellitus 1 Yes 2 □ 25. Was case referred to medical examiner?
1 Yes 2 No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Prevision 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W. um MD, PhD RES-000 December 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Chelsea C. Pinnix

31. Date filed (Month, Day, Year)

MD, PhD

Sinai

2. Registrar's Signature

Hospital of Baitimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12-10 Physician -00°7 450 A NJE /Medical Facility Name (If not institution, give street and number) Examiner Howard Healtha 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth **Funeral** 1 □ M 2 ▼ F Director 10c. City Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at essu 1 XYes 2 No Director owa 10g. Citizen of What Country? 10e. Street and Number USA 20794 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify <u>م</u> Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19a Informant's Name/Relationship (Type. PfitGrand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8719 Jessup, MD 1Stephenson Nary ane 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State 18/07 Baltimore, MD f Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ere /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, and the limit of the line of the lin Physician/Medical Examiner Due to for as a consequence of the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 ☐ Other (specify) signed by the al d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has t lirector, page 2 s autopsy performed death? 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be Place of in jury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) DEC 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Holietrar's Signature

Sperks

Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 18:10 PM **VENETOULIS** BAOURIS NIKOLE DECEMBER 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BACTIMORS CITY SINAI HUSPITAL OF KALTIMORS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. August 3, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 916 **Funeral** 1 □ M 2 😿 F Greece 214-12-9464 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 24 Woodward Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) 8th Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Zaharoula Kasiotis Nicola Baouris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 24 Woodward Lane Lutherville, Maryland 21093 Theodore Venetoulis Son if item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Greek Orthodox Cemetery 12/13/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral ry/ce Lice/see 6500 York Road Baltimore, Maryland 21212 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death e, or complications t List only one cause Immediate Cause (Final disease or condition resulting in death) PNSUMONIA 1 WESK **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 2 100 1□ Yes 2 No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21940 P 1 Impatient 2 □ ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After (Month, Day Year) Hospital or Attending 1 Natural 5 Pending investigation the Funeral Director. M 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number DOD 63430)ECEMBER 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF SINAI S. KHUNKHUN AVITET 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WARREN 9:30PM LUCILLE DECEMBER 8 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 8. Date of Birth (Month Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**V**F Months Days Hours -22-5864 Director 10a. State 10c. City, Town or Location 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 es 2 No hmore 10e. Street and Number 10g. Citizen of What Country? 21202 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 21 If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 M No þ Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stod permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other? Mather's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname, Be Qa. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) , Baltimore, MD 21213 aughter) 3630 Her) 3630 Lyndale

20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State 21. Signature of Funeral Service Licensee any 5151 Baltimore Nat'l Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart is lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assiration Prestonia **Physician** I week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anoxic BRAIN INTURY 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed GLUTEAL ULCER P.O. Box 68760, ₹ and burial-trar Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) the p signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 has autonsy performed? certificate 1∐ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 XInpatient ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , MEDICAL DOCTOR RES-000 DELEMBER, 8, 2007

Registrar

31. Date filed (Month, Day, Year) DEC 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 17FM/18, perFH, C874, 12/12/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** A Homewood Genesis 13al hmore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Qountry) **Funeral** Days Hours 3-32-6641 1**∑** M 2□ F 33 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show Oc. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No ıral", or items 23a or 28a-f sh Examiner must be notifled Funeral Director M.D BAITIMOR 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 2015 A. 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAbor 5th GRADI CAN CO. BETIREQ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene W: KERKON imort Mi 2/2/2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) December 13, 21 Signature of Funeral Service Licensee 22. Name and Address of Facility etts suggest Hon BAITI alreace) 23a. P. n.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 40000 UAD /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Gussaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed for use as the burial-transit been signed by the attending physician and should be detached for use as the hurial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown decobitios vilas 24b. Were autopsy findings available prior to completion of cause of death? Infected 24a. Was an autopsy performed? Gramia 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 → 1/0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31295 12/7/01 www. 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Susta 4202 76 W500 KIHSZ 2/204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend #28f	Per ME 6874	12717	Apartment of l Certificate of	Health and Mo		ene 2007	39829
-	Physicia /Medic		1. Decedent's Name (First, Middle, I Paul Joseph W					2. Date of Death Month DCCem60	Day 8 Year	3. Time of Death
	Examin Funeral Director		217-38-3186	1 of Ball	rimores n yrs. last birti	Balti	Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death N/A N/A (ear) 9. Birthp Count 194 Vir	lace (State or Foreign try) 'Ginia
	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County N	/A 10	oc. City, Town	or Location Baltimor	e		1	0d. Inside City Limits XXYes 2 □ No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 2518 Loyola N	orthway		10f. Zip Code	21215	10g	Citizen of What Coun USA	try?
25 J	be filed within 72 hours after death with the Maryland ntal Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: B1	
PAU 21215-0	within 72 ene. than "nai he Medica	Completed by	15. Decedent's (Specify only highest state) 1 2th Grade	College (1-4or 5+)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Tailo	during most of working ed)	g	age Men's	
ER yland	should be filed nd Mental Hygi marked other imatic event, tl	Φ	17. Father's Name (First, Middle, La Preston Winkle	r 			18. Mother's Name Fannie	Jaughn	,	
KLE, Mary	and 2 sho ealth and N n 27 is ma her trauma		19a. Informant's Name/Relationship Tyrone Winkler	/ Son	25	Mailing Address (Street 18 Loyola	Northway	y Balti	City or Town, State, Zip MOre, MD	^{Code)} 21215
WLN	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Hemoval from State	20b. Place of cemeters Arbut	Disposition (Name of y, crematory or other pla us Memori	ace12/13/0° al Park) ^{te} 20	c. Location - City or To rbutus, M	
W Baltii	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lic	ensee arris					rris Fune altimore,	eral Home MD 21215
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the dy one cause on each line. a. A. J. H. Due to (or as a co	Myon	cardial	ing, such as cardiac or	respiratory arrest	WAAMIN'S	Approximate Interval Between Onset and Death
	Examiner guille	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. SMO X Due to (or as a co		ENMALA DE ROWN IN	4TION	ATION APPROVEDS	WINEDON EXAMINE	3 days
38760,	cate be	dical	resulting in death) Last	Due to (or as a co		· _		URNJ.		3 days.
Division or Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) □	y		23d. Date of delive	ry Day Year
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to the	
l Reco	sician: The law rer certificate has bee rector, page 2 shor	Completed						24a. Was an autopsy performe 1 Yes 2 □	d? prior to cor death?	psy findings available npletion of cause of 2 \square No
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vision o	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine	be 28e Place of injury	At home far	jury Wo	Yes 2 No	Bd. Describe how Fire - Bf. Stration (Street	injury occurred HOUSE Five	(C L Boute Number,
ρ	ospital or A nours after ineral Dire y filled in by		29a. Certifier 1 Certifying	building, etc. (S	Y NOWledge.	death occurred at the ti	ime, date and place, a	5/8 LO	ACK TOOK	way -
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 ☐ Medical Ex. 29b. Signature and title of certifier	aminer: On the basis of exand manner stated	amination and	or investigation, in my	opinion, death occurre 	d at the time, date	e and place, and due to Date signed (Month,	the cause(s) Day, Year)
	1	-	30. Name and address of person wh	o completed cause of death	(Item 23a) (T	29c. Licens Do	0 6537	4 1	Desember	8,2007
	Stat	e	Agan Labino 31. Date filed (Month, Day, Year)	P. Registrar's	Signature	inai	Mospi	tal c	+ Balt	MOILE
	Registra	-	DEC 1 2 20	07 Blown .	B A	nade				

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 1

Reg. No. 1

Reg. No. 2 39830 Reg. No.Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Westry,SR. \mathbf{E}_{ullet} Louis Day Year **Physician** cstra 11/8 A M November 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalistown Hospita Baltin thwest ore 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2□ F Hours Min 03 NC. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore Randallstown ns 23a or 28a-f sh must be notified MD 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? inlee Road WSA 1004 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2750 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Completed by Specify. Specify: Black 3 Widowed 4 Divorced "natural" other than "natu vent, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James n cas ဥ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown MD Health a Brenda t004 Winlee Koad or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 Burial 2 □ Cremation 3 Removal from State Baltmore, MD voutus Cemeten 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Volugian C. Greene Funeral SVCS 8728 Liberty Road Randal Istown MD 21/33 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) preumonit /Medical Examiner to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transit Muetiorgan Due to (or as a consequence of Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably ✓ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a. Was an After this certificate has autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Xxpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending F after death. XX Natural 5 Pending investigation Injury 1 ∏ Yes 2 ∏ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Fo the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the Ho within 24 h 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

State

MP

Registrar's Signature

5401012

and address of person who completed cause of death (Item 23a) (Type, Print)

essa Edelman MD

2007

31. Date filed (Month Da

0006617

Court Road

November 21 2007

Randallstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wallace Day Physician Month December 6, 2007 orren /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Tawn, or Location of Death 4c. County of Death Examiner Daltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) March 11, 1960 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Rountry)
Mary land 5. Social Security Number 6. Sex **Funeral** Months 217-84-9700 1 □ M 2 1 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1 Yes 2 No Director Mary land 3altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 "natural", or items 23a Untel States Shipulew Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes WNo If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 No Specify: þ Slack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) Coilege (1-4or 5+) eachers Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Moire, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau Maryland 21218 Baltimore Harris arley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 □ Cremation 3 □ Removal from State Western Baltimore MD Dec. 12 2007 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
ALUIN L. WILLIAMS 21. Signatur of Funeral Service License CALVIN L. WILL
270 Fred helton alvin I. Wittend Fass. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE LIVER DISFASE UNICNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HEPATINS
Due to (or as a consequence of) The law requires that the death certificate be exer Box 68760 Physician/Medical use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PUEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Be Completed ENCEPHALOPATHY Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an the funeral director, page 2 autopsy performed 1∐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide the Hospital within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar DHMH 17 Rev 1/2001

m

29b. Signature and title of certifier

(Month, Day,

DEC 1 2 2007

30. Name and address

31. Date filed

who completed cause of death (Item 23a) (Type, Print)

29c. License number

AMPTRE, COLUMBIA,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12/8/07**Physician** THOMAS М WILLIAMS 7:20 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH CATONSVILLE **Baltimore** CATONSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 / 23 / 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 247 32 1863 **Director** Virginia 84 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Yes 2□No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 817 LYNDHURST STREET 21229 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. □Yes 2□ No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Black Top Works the Asphalt Construction 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millie Dye Andrew Williams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i 817 Lyndhurst Street Baltimore, Maryland 21229 Doris Binns Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department o Important: If i any injury or once. 1 Burial 2 Cremation 3 Removal from State 12/13/07 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) Western Cemetery 21. Signature of Funeral Service Liceris 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the dea shock, or heart/failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician 4 St /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: f yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a e Funeral I 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the within 2 To the I 29c. License number 29b. Signature and title of certifier ex Rd. Ceforsville, Mp 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My 1009

State Registrar

31. Date filed (Month, Day,

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrer	te of Maryland / Dep Ce	partment of Hertificate of L			ne . 2007	39833
Physic /Med		1. Decedent's Name (First, Middle, Last)	ams			2. Date of Death Month	Day Year	
Exami	ner	4a. Facility Name (If not institution, give street a Caroline Ho 5. Social Security Number 6. Sex	nd number) Spice , 7. Age (In yrs. last birthda	Der	Location of Death 1 + 0 n If Under 24 Hrs.	8. Date of Birth	4c. County of Death Carol 9. Birth	ine
Funera Director		218-24-2686		Months Days	Hours Min.	(Month, Day, Y 07–29–1		intry) 10d. Inside City Limits
the Maryla 28a-f shov	ector	Md. Caroline	Dento			100	. Citizen of What Co	1 Yes 2 No
death with ms 23a or	Funeral Director	26745 Shore Hyway		216 3. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	USA 14. Race - Amer	
5-0036 72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jical Evanirer must be notified at	þ	1 Never Married 2 Married 1 If Y 3 Widowed 4 Divorced Ye.]Yes 2 No es, Give ar or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	lack
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Maryland 212 d 2 should be filed within th and Mental Hygiene. 77 is marked other than traumatic event, It a M	To Be C	17. Father's Name (First, Middle, Last) Edgar Nichols			Viola		ond	U- Code)
ME nd 2: alith ar 27 Is r trau		19a. Informant's Name/Relationship (Type, Pri Patricia Adams/Dau 20a. Method of Disposition	ghter 267	illing Address (Street at 49 Shore position (Name of rematory or other place	Hyway,	Denton.		21.629
Ballimore, permit. Pages 1 a Department of Hec Important: If item any injury or othe		1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. Consture of Funer I Service Licensee	Federal	Hill Ce	em. 11-2 ss of Facility Benn	nie Smit	th Funera	
Pnysiciar /Medica Examine			that caused the death. Do not est on each line. Failure To Due to (or as a consequence of):	426 DOVE	g, such as cardiac	or respiratory arres	0.21001	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):					
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w requires that been signed b should be deta	þ	Part II. Other significant conditions contribution	ng to death but not resulting in the	underlying cause giv	en in Part I.		acco use contribute to	the cause of death?
	Completed	7					ed? prior to death? ∃No 1 □ Yes	ltopsy findings available completion of cause of 2□ No
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To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: 0 one)	To the best of my knowledge, de in the basis of examination and/or ad manner stated.	eath occurred at the tir investigation, in my o	pinion, death occur	red at the time, da	use(s) and manner as te and place, and due d. Date signed (Mont	to the cause(s)
Viiti To	2	29b. Signature and title of certifier	DA	den Da	,4973		11/20/	2007
3		30. Name and address of person who complete Stephanic D Silve 31. Date filed (Month, Day, Year)	ed cause of death (Item 23a) (Typer MD 2) Registrar's Signature	se, Print) 5 Bloom	ingdale A	tre fea	deralsbu	rg MD 2163
S Regis	tate trar	NOV 2 6 2007	Many H. C	110				

07-09172 Husnara Ashraf Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 39834

ara Asiliai			Certificate of	Death	Reg.	No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			Date of Death Month D	3. Time of Death	
Examir		Husnara Ashraf			November 2	6, 2007 4c. County of Death	
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Bethesda	of Death	Montgomery	-
		Suburban Hospital			er 24Hrs. 8. Date of Birth	MM/DD/YYYY) 9. Birthplace (State or	
Funeral			yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours		,1946 Foreign Pakista	en
Director	ľ	339-86-9967 _{1 M 2} X _F	61 _{Yrs}		1.52.02	oddinity/	
	Ì	Usual Residence of Decedent	City, Town or Local	tion		10d. Inside City I	Limits
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nd show	5	Maryland Montgomery Ge		10f. Zip Code	100	. Citizen of What Country?	
faryla 28a-f 1 at o	Director	10e. Street and Number		20874	1	Pakistan	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ᅙ	20525 Summersong Lane		as Decedent of Hispanic Or	igin2 / Specify Yes or No-	14. Race - American Indian, Black	ί,
with ms 23	erai	11. Marital Status 1 Never Married 2 X Married Armed Forces?	If '	as Decedent of Hispanic Of Yes, specify Cuban, Mexical	n, Puerto Rican, etc.)	White, etc.	
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withi withi	Completed	17. Father's Name (First, Middle, Last)		18.Moth	er's Name (First, Middle, M	aiden Surname)	
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Z 1 Z ald be Ment mark e ever	일	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and No	umber or Rural Route Num	ber, City or Town, State, Zip Code)	
2 short and 27 is matic		Syed F. Ashraf, son			Date Date	town, Md. 20874 20c. Location - City or Town, State	
e, R and Health item		20a. Method of Disposition	20b. Place of Disp	osition (Name of cemetery, other place) Onal Mem. Park		Laurel, Maryland	
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ICIN iit. Partmei		Donation 5 Other Specify: 21. Signature of Funeral Service License	132	Name and Address of Faci	Wardt Funera	l Home, PA sville, Maryland 2	2070
Dep Termini			44	400 Powder Mi	11 Road Belt	est, shock, or heart Approximate	Interval
ysician	Г	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not ente	r the mode of dying, such as	s cardiac or respiratory arre	Between Ons	iset and
/ledical		Immediate Cause (Final disease a. Multiple Injuries					
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SiO Atten deatl	ğ	2 Accident Investigation 28e, Place of Inju	ury - At home, farm,	street, factory, office building	ng, etc. 28f. Location	(Street and Number or Rural Route Num	mber, C
JV is after all Direction	ui pa	Suicide 6 Could not be 1	or Road / High		Route 118 8	State) & Crystal Rock Drive, Germantown,	, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and To the Function: After this certificate has been signed by the attending physician and the function of the control by the death-of for use as the burial—transition.				and at the time date ar	nd place, and due to the ca	use(s) and manner as stated.	
the H iin 24 the Fu	plete	one) and Medical Examiner: On the basis of exam	nination and/or inves	stigation, in my opinion, dea	ath occurred at the time, dat		-
To t To t	COIL	and manner stated. 29b. Signature and title of certifier		29c. License nur		29d. Date signed (Month, Day, Year	r)
		I de marked -		O.C.M.E	DOME	November 27, 2007	
T		30. Name and address of person who complete cause of de	eath (Item 23a)				
		Theodore M. King, Jr., MD. Assistant M.	edical Examine	er 111 Penn Street	t, Baltimore, MD 212	01	
4	Q4	100 mintros	r's Signature	Road a			
Pac	Sta pisto	NHV GO ZUUT FTFARA	w st. p				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 4:48pm Bedrosian Jack 2007 Nov. 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Park 6200 Westchester Park Drive Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth July 12, 12924 9. Birthplace (State or Foreign New York 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 MM 2 ☐ F 103-20-0996 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 XYes 2 □ No Director MD Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6200 Westchester Park Dr. 20740 Funeral 12. Was Decedent Ever in U.S. Anged Forces? 1 Eyes 2 Thknown If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: by 3 Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jeweler Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tomboulian Edward Bedrosian Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roswitha Nicholas/Sister-in-Law 1400 Earlshire Place, Plano, TX 75075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-27,2007 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions. Due to for as a consequence of drary, letting to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as attending for use as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Hypertension, Chronic Renal Insufficiency 1 Tes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1□ Yes 21 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other; 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 November 26, 2007 D55559 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. #316 Greenbelt, MD 20770 Thomas E Maslen MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 28 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30A.M November 26, 2007 Ernest Edward Burkhardt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan . 1,1931 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 578-36-5022 1**X** M 2□ F 76 Maryland Yrs. **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince George's Beltsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20705 United States 4723 Naples Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 10/0 10 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: 1949–1950 Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Automotive Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable Curtin Frederick Burkhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, C. Robert Burkhardt -son 35 Howard Street, S.E. Atlanta, Georgia 30317 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 12/1/2007 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²²Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** End Stage Chronic Obstructive Pulmonary Disease vears disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Weight Loss 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? res 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C t 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 November 27, 2007 D51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres E. Salazar, M.D. 3621 Ligon Road Ellicott City, Maryland 21042

State

Registrar

31. Date filed (Month, Day, Year) NOV 28

2007

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ľ	1 - For State Registrar	State of	Marylan	•	artment o			lental Hygi	ene 007	39837
	Physici	an	1. Decedent's Name (First, Middle, L	-						2. Date of Death Month 12/5	Day Year	3. Time of Death 2:24PM
3"	/Medic Examin		John B. Brown, S		ber)		4b. City, To	wn, or Locat	tion of Death	12/ 3	4c. County of Dea	
	LXamii	ÇI	5502 Bonnie Broo	k Rd.			Can	nbridg	e		Dorchest	ter
	Funeral Director		213-09-8096	Sex 1 M 2 □ F	7. Age (In yrs. 90		If Under 1 \ Months D	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, 7/24/	9. Bir 1917 Mary	thplace (State or Foreign buntry) yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	, Town or Lo	ocation					10d. Inside City Limits
	Maryl -f eho	ţ	Maryland Dorches	tor	Ca	mbridg	re.					1 ☐ Yes 2 X No
	th the	lrec	10e. Street and Number	CCI			10f. Zip Co	ode		10	g. Citizen of What Co	ountry?
	ath wi	ral	5502 Bonnie Broo					216			USA	
	Itsma Itsma	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced	dent Ever in U. ces? 2 DNo 194	s. 13.1	_		c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
920	urs aff	þ	3 XWidowed 4 □ Divorced	If Yes, Give	ces? 2 □ No 194 etes: 194	6	1 □ Yes 2 2	No Spe	city:		Specify: W	nite
S S	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or items 23a or 28a-f ehow ent, it is Mudical Examinar rout be notified at	Completed	15. Decedent's (Specify only highest g			16a. Dece	dent's Usual C	Occupation done during	most of work	ing 1	6b. Kind of Business	Andustry
12	within one. then	dE	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work of DO NOT use				Healthcare	3
9	filed v Hygie other I	ပိ	17. Father's Name (First, Middle, Las	2st)		позрт	Lai Adii			e (First, Middle, M		
lan.	Aental Aental rked c	То Ве	Joseph F. Brown					Α	nn Byr	nes		
Maryland 21215-0036	and N is ma		19a. Informant's Name/Relationship	(Type, Print)							City or Town, State,	
e) •	1 and Health em 27 ther tr		Blaise J. Brown/	Son	20h P						tNew Marke Oc. Location - City or	et, MD 21631
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f ehow shy injury or other treumatic event, the Mudical Examination at the notified at ODEs.		1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		kate		natory or othe					
Ħ	nit. Poertme	i	21 Signature of Funeral Service Lic		Gree		Cemete 2. Name and 2				Cambridge,	LID CILY
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89	tificate ig phy as the	ledic		d								
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	at the dea by the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of di wn	eath 5	Other (spec	:ify)			World	buy tour
P.0	res that t igned by be detac	by Ph	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying caus	se given in P	Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	w requires been sign should be									1 🗆 Ye	s 2ŒNo 3□P	robably 4 □Unknown
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	Ø		30. Name and address of person who BRENDUN PAL	TOO 1	05 A	turoy	Print)	treet	- Ca	mbridg	e MD	21613
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 2 2	007 Re	egistrar's Sign	Aure App	also I					

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he Ho in 24 he Fu	Medical	(Check only one) 2 Medical Examin	er:On the basis of e	xamination a	and/or investiga	ation, in my opi	inion, death or	ccurred at	the time, date	and place, and due	to the cause(s)
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	-		. 1	1		0	.C.M.E.			November 23	3, 2007
		4	, MIC	of death /Item	n 23a\		 -				
8		30. Name and address of person will Jack Titus MD. Deputy	o completed cause o y Chief Medical			enn Street,	Baltimore,	MD 21	201		
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Regist	ate rar	DEC 0 4		filled d	13. Page						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 39839

		- For State	,	Certifi	icate of	Death_				Reg. No).		
Physicia	ın/	Decedent's Name (First, Midd	le,Last)						2. Date of Month	Day	Year	3. Time of 0821	
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3		4a. Facility Name (if not instituti Union Hospital	on, give street and r	number)	41	o. City, Town, Elkton					Cecil		No. or
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Director	1	219-79-5000	1M 2 X F	0	Yrs.		9	,010	OCT.	26,	2007	Country) M	J
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vith th		11. Marital Status	12. Was D	ecedent Ever in U.S.	13. Was	Decedent of	Hispanic	Origin?	(Specify Yes	r No-		American Indian	Black,
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Baltimore, bermit. Pages 1 an Department of Hea Important: If iter		1 X Burial 2 Cremati	on 3 Remova	I from State	matory or ot	ner place)	12Th		10/00/		work		N.M.
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex-		21. Signature of Funeral Service	ce Licensee		SP.	CER-MI	JLLIK	TN 1 IT PI	FUNERAL	HOM	ES ASTLE.	DE 1972	0
Physician		25a. Part I. Enter the disease,	or complications that	at caused the death. D	Do not enter t	he mode of dy	ing, such	as cardi	iac or respirato	ry arrest,	shock, or hea	art Approx Between	imate Interval en Onset and
We dical	QE 15	failure. List only one caus	se on each line. se a Sudden	unex lained	death	in infar	cv (5	(III					Death
aminer		or condition resulting in death		as a consequence of):				200000					
	<u></u>	Sequentially list conditions, if any, leading to immediate	b Due to (or a	as a consequence of):									
	Ë	cause. Enter Underlying Cause. (Disease or injury that initiated	С.						_			-	
cuted and transit	Examiner	events resulting in death) Las		as a consequence of):									
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'60, cate be ex physician he burial	Medical	IF FEMALE:	23c. If ye	es, outcome of pregna	ancv						23d. Date of	-	Vaar
Ox 687 ath certific		23b. Was decedent pregnant in past 12 months?		ve birth regnant at time of deat		etal death		ctopic pr	regnancy		Month	Day	Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 V No 9	Intracum	nknow n	^{tn} 5 O	ther (Specify,				_	_		
C, th		Part II. Other significant con	ditions contributir	ng to death but not res	sulting in the	underlying ca	use given	in Part				ribute to the caus	
P.O. ires that to signed b	d by						·					Probably 4	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	ompleted								24a	. Was an autopsy		Were autopsy fin prior to completio	n of cause of
tal Records rian: The law requi certificate has been ector, page 2 should	ဋ								1 🗸	perform Yes 2		death? I ✔ Yes	2 No
Vital Rec ysiciau: The his certificate director, page	0	25. Was case referred to med				26.		· ·	heck only one)				
Vita tysicis this ce direc	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 I					Nursing Home		esidence 6	Other:	
Jof Jing Ph After t	=	27. Manner of Death	(N	Date of Injury Month, Day, Year)	28b. Time of	,	. Injury at		. .	scribe no	w injury occu	rea	
ttendi ttendi death.	atie	1 Natural 5 P 2 Accident	ending vestigation Fnd	12/5/2007 Place of Injury - At ho	Fnd 7:4	Uami				ation (Str	eet and Num	ber or Rural Rout	e Number, City
Division pital or Attendiours after death. reral Director: Affiled in by the fu	Certification:	3 Suicide 6 X C	ould not be 28e. I (Sperior		la thom		nce bund	ilig, etc.	117 or 3	own, Sta	te) ev Dr. I	Elkton, MD	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a Ceruiter	Dhusisian Tatha	heat of my knowledg	e death occ	irred at the fir	ne, date a	and place	e, and due to t	ne causei	s) and manne	er as stated.	
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical E	xaminer: On the ba	asis of examination an	nd/or investig	ation, in my o	oinion, de	ath occu	urred at the tim	e, date ar	nd place, and	due to the cause	(s)
To with	Sec	29b. Signature and title of cer	and mann	ner stated.		29c. l	icense nu	umber			_	ned (Month, Day	, Year)
		Pot	Dom.	- Holl	Lon		D.C.M.E	Ξ.			Decembe	r 6, 2007	
		30. Name and address of per								04001			
		Patricia Arpnica-Po		sistant Medical E		111 Per	ın Stree	et, Ball	timpre, MD	21201			
	State stra	31. Date filed (Month, Day, Ye		2. Registrar's Signatu	Goods	U							

uted the permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Medical Examiner must be notified at once.		ж.	Fur	nera
Physician /Medical Examiner	E		JIFE	CIO
LXamme	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show	any Injury or other traumatic event, the Medical Examiner must be notified at
	7	Ph //	ysi Med	ciar lica
uted d ansit		_^	G	
		cuted	P	ransit

1- For State Registrar

			1. Decedent's Nan	me (First, Middle, La	ast)					_		2. Date of Dea		<u> </u>	3. Time of Death
	Physic /Medi		PAULINE LOUISE DAVIS									NOVEMB1	ER 17	2007	4:00PM M
1	Exami		4a. Facility Name	(If not institution, gi	ve street and num	ber)		4b. City,	Town, or	Location of	f Death		4c. Cou	inty of Death	
		×		OT HOSPIC					ASTO					TALBOT	
ı	Funeral Director	П	5. Social Security 214–42–7		Sex 1□M 2 X F	. Age (In yrs. Ii 64	a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birtl (Month, Day JULY 1	Year)		place (State or Foreign Intry) (LAND
E.	ס		Usual Residence]]							
	urylan show	_	10a. State	10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	he Ma 8a-f s	ecto	MD	TALI	BOT		EAST								Yes 2 No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	Funeral Director		10e. Street and Number 1070 N. WASHINGTON ST., APT 10					10f. Zip Code 10g. Citizen of What Court 3 USA						intry?
	leath ns 23 must	era	10/0 N.	WASHING.	12. Was Deced	ent Ever in U.S		Was Decer	2160 dent of His		nin? (Snec	cify Yes or No-		A Race - Ameri	can Indian
(0	or iter			rried 2 Married	Armed Ford	es? KN No	- 1				, Puerto F	cify Yes or No- Rican, etc.)	E	Black, White	
03	ours a ral", c	by	3 Widowed	4 Noivorced	If Yes, Give Year or Dat	es:		1 ☐ Yes	2LM0	Specify:			Spe	ecify: WH]	TE
5-0	72 he 'natu dical	etec	(Spe	15. Decedent's E	ducation rade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition uring most	t of workin	g I	16b. Kind o	f Business/Ir	ndustry
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Sec 12	ondary (0-12)	College (1-4	lor 5+)		DO NOT US	se retired)				FOOD	SERV	CE
	be filed tal Hygi d other event, ti	Be	17. Father's Name	(First, Middle, Las	t)							(First, Middle,		name)	
<u>Ya</u>	ould be Mental rarked o	ည		B. LOMAX			т					E. NEW			
Maryland	12 sho h and 7 Is ma trauma			Name/Relationship SNYDER								Route Numbe			p Code)
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Baltimore,				Cremation 3 5 Other (Special		ate	emetery, cire RING F			· i	11/2	6/2007		-	ARYLAND
Ħ	permit. Page Department (Important: If any Injury or			uneral Service Lice	• •									•	HOME PA
ä	permi Depar Impor any Ir		1	Y CH	MERC	EROF						& NEWNA ASTON,			HOME PA
			23a. Part1. Enter shock, or he	the disease, or con art failure. List only	nplications that cau one cause on eac	used the death ch line.	. Do not ent	ter the mod	e of dying	j, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
N	Physician		Immediate Cause	on	a. Non	Smill	1011	Wr	vs C	W(i	~on	nd			Onset and Death
1	/Medical Examiner		resulting in death)		Due to (o	r as a consequ	ence of):	0	/						
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	uted 1 ansit	Ē	cause. Enter Und Cause (Disease o	erlying r injury											
Ć	execting and signification and	Examiner	that initiated event resulting in death)	Last	Due to (o	r as a consequ	ence of):								
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% 68	ertifica ling pl e as t	Med	IF FEMALE:			_									
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	s that med b	y P	Part II. Other sign	ificant conditions	contributing to dea	th but not resu	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death?
ord	w require been sig should b	edt	Chron	11C 061	TRULTIVE	· Null	MANON	y 2	illes	25		1 🗆 Y	es 2 □ No	o 3⊡Pro	bably 4 ☐Unknown
or Vital Records,	law re as be 2 sho	plet	CONS	CITIVE	HENT	Prilu.	11 /					24a. Was a		b. Were aut	opsy findings available ompletion of cause of
<u>=</u>	sician: The law certificate has b irector, page 2 s	Soli										perfor	med? 2 No	death?	2 No
/ita	cian; sertific	Be	25. Was case refe examiner?		Headhala						of Death	(Check only or	ne)		
or	Physician: r this certifica ral director, p	2	1 Yes 2 2 27. Mann ea		Hospital: 1 ☐ Inp		ER/Outpatier			4 ∐ Nui					fy) HOSPICE_
O	ding F h. After funera	Ö	1 atural	5 Pending investigation	(Month,	Day Year)	Injury	' M 2	8c. Injury Work 1 □ ∨	at ? ′es 2∐1		8d. Describe h	ow injury oc	curred	
Division	Attending It death. ector: After by the fune	fical	2 Accident 3 Suicide	6 Could not be	e 28e. Place o	finjury - At hor	me, farm, str			C3 Z	-	8f. Location (S	treet and Nu	ımber or Rur	al Route Number,
Ö	s after al Dire	Certification:	4 ☐ Homicide	dotomino	building	, etc. (Specify)					City or Tow	n, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 ☐ CertifyIng P 2 ☐ Medical Exa	hysiclan: To the bas miner: On the bas and manne	is of examinati	vledge, deatl ion and/or in	h occurred ivestigation,	at the tim , in my op	e, date an	d place, a th occurre	nd due to the o	cause(s) and date and plac	manner as s	stated. to the cause(s)
	To the To the Compl	Me	29b. Signature and	d title of certifier	1	7/		29c	License	number		2	29d. Date sig	ned (Month,	Day, Year)
) w	By 11	is the	mon	20	1	31	466			11/1	19/0	7
	3		30. Name and add	ress of person who	completed cause	of death (Item	23a) (Type,	Print)					-//	//-	/
			*	J. EGLSEI				MOOD	DRIV	E, E	ASTON	, MD 2	1601		
	Sta Registi	_	31. Date filed (Moi	"NOV 2 0	2007 32. R	istrar's Signat	ure A	Lock							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 10:10 am Charles Eugene Edwards IIIDecember 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44036 Flagstone Way California St. Mary's 5 Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 52-3764 Director 80 04/28/1927 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Funeral Director Maryland St. Mary's California 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States

14. Race - American I
Black, White, etc. 44036 Flagstone Way 20619 - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Physician</u> <u>Neurology</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pheobe Lynch ျှ Charles Eugene Edwards, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth N. Edwards / Spouse 44036 Flagstone Way, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 12-5-2007 | Charlotte Hall, MD 21. Signature of Euneral Service Vices are Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YATK, ~500 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 💜 o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes Certification: To funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1)Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 YertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29b. Signature and title of op

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

on who completed cause of death (Item 23a) (Type, Print)

2007

Harry G. Kerasidis, M.D.,

31. Date filed (Month, Day, Year) DEC 0 6

29d. Date signed (Month, Day, Year)

55 Stoakley Rd., Prince Frederick, Maryland 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per alt of 8875 and 12408 dhent of Health and Mental Hygiene 17 Registrar Amend Items 23a, 25 per ine, g874 delibrate of Death Reg. No. 39842 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER®7 20°7 3:08 am CLARENCE JOSEPH EDWARDS, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Chester River Hospital Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 24. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1932 Maryland 1 XM 2 ☐ F 74 Yrs. 215-32-2199 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Kent Millington Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 34515 Cypress Rd. 21651 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 10 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event <u>gote</u>. 17. Father's Name (First, Middle, Last) Eva Mary O'Neal John Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (wife) 34515 Cypress Rd. Millington, MD. 21651 Jean P. Edwards 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/10/07 Massey Cemetery Massey, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Flun ral Service Licen ser Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Atherosclerotic Cardiovascular Disease** Immediate Cause (Final disease or condition resulting in death) AGRES Physician /Medical Due to (or as a consequence of): Examiner OCACOIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER to the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARCINOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2K No 2□ No certificate 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 →Yes -2 → Yes 1 ⊠inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier unn Mh November 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Paul R. Johnson, 400 S. Cross St.Chestertown, MD. 21620 M.D.32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 1 2007 SARKES Registrar

	-	For State	State of M	laryland		artment of F rtificate of		Mental Hy	- /	007	39843
4 * **		Registrar 1. Decedent's Name (First, Middle,	Last)			incate or	Death	2. Date of D			3. Time of Death
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/Medica Examine	ya.	4a. Facility Name (If not institution,	give street and number	-)		4b. City, Town, o	r Location of Death	1	4c. C	County of Deat	th
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Funeral Director		579-64-4015	6. Sex 7. A 1 M 2 □ F	ge (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May 27	a <i>y, Year)</i>	Co	thplace (State or Foreign ountry) Ermany
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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0 0 = 1	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Deceden Armed Forces at 1 Yes 2 If Yes, Give	?	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)		4. Race - Ame Black, Whit Specify:	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exalonce.	ted by	3 Wildowed 4 Divorced 15. Decedent' (Specify only highes)	Year or Dates s Education	:	16a, Dece	dent's Usual Occup	pation	kina		d of Business	Thite /Industry
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Ment arked	2	Robert M.	Goedec	ke			Suzanr		Ke11		
d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationsh Norman J. Goede	_			ng Address (Street Barton					
Healt Healt tem 2	-	20a. Method of Disposition	cke/30ff	20b. Pl		sition (Name of matory or other place		Date		ation - City or	
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permit. Departra Importa any inju		21. Signature of Funeral Service	1111/2	n008					Home arlot	, P.A.	L, MD 20622
2F	+	23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that cause	ed the death	·						Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or a	s a consequ							
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6								
cate be executed physician and the burial-transit	EXa	resulting in death) Last	Due to (or a	s a consequ	ience of):						
cate be	dical	7.7	d								
ding pase as	Φ ⊦	IF FEMALE:	23c. If yes, outcom	e of pregna	n.cv.						P
ne death certific the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>	у		23	3d. Date of de Month	Day Year
w requires that the d been signed by the should be detached	H.	Part II. Other significant conditio	ns contributing to death	but not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	o the cause of death?
quires n sign ald be	d by							178	Yes 2□	No 3□P	robably 4 Unknown
law recast law recast	Completed							24a. Wa	psy	prior to	utopsy findings available completion of cause of
sician: The law certificate has the certificate has the certor, page 2 s	5							per 1⊡ Yes	formed? 2 No	death? 1 ☐ Yes	s 2 No
Physician: this certific ral director,	e e	25. Was case referred to medical examiner?	Hospital:			ot 3 DOA Oth	26. Place of Dea				Son's
Physer this eral di	<u> </u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of In	jury	28b. Time o	1 0 DOX	4 🗀 Nursing F	lome 5 Res			ecify) Residence
nding th. r: Afte e fune	Tio	1) Natural 5 ☐ Pending 2 ☐ Accident investig		ay Year)	Injury		rk? Yes 2∐No				
or Atte frer des Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ned 20e. Place of II	njury - At ho etc. (Specify		eet, factory, office		28f. Location City or To	(Street and own, State)	Number or F	Pural Route Number,
	Medical Ce		g Physician: To the bes Examiner: On the basis and manner	of examinat							
To the within: To the comple	Mec	29b. Signature and title of certifier		1		29c. Licens	se number 00557	5-1			th, Day, Year)
b_{i}	-	30. Name and address of person v		death (Item	23a) (Type,	Print)				2-3	-UT
V.		Dr. Jennifer S					rdtown, M	D 20650			
State Registra	100	31. Date filed (Month, Day, Year) DEC 0	4 2007 32. Pois	trar's Signal	ture	port					

Box 68760. P.O. I Records, Division or Vital death. Director:

letely filled in by the funeral director, page 2: le Hospital or Attending Physician: in 24 hours after on the Funeral Direct

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatu 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) D62288 12/05/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nikhil Uppal, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

31. Date filed (Month, Day, Year) DEC 0 6

determined

3 ☐ Suicide

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certificate of Death

10:40AMM

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

Dav

Reondi

1 ☐ Yes X No

MARYLAND

USA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

registrar's Signature

JR.

2007

WOOD,

WILLIAM H.

State Registrar

DHMH 17 Rev 1/2001

M.D., 501 DUTCHMANS LANE, EASTON, MD 21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 29, 2007 **Physician** 10:55p Elizabeth Dannaway Hunnicutt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 971 Crystal Rock Road Lusby Calvert If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 1 □ M 2 🕱 F Months Days Director 578-30-9685 81 May 29, 1926 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ss 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. USA 971 Crystal Rock Road 20657 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 ☐ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 27 Is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operater Glass Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pear1 Rurke Donaldson Car1 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Hunnicutt/Son 13250 Oaks Road, Charlotte Hall, MD 20622 permit. Pages 1 a Department of Hee Important: If Item any Injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Suitland, Maryland 12/4/2007 Cedar Hill Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service Lie M008/7 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lung Cancer disease or condition resulting in death) /Medical Due to (a consequence of) Examiner ynzea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably V ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 140 this certificate 1□ Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No dea h. 2 Accident Director in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or / within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (Check only 2 Medical Examiner: \$\phi\$ the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A-NASR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 3 2007

225 Townsquare Br

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760 n 24 hours after death. The Funeral Director; A bletely filled in by the fi

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MDD60925

29d. Date signed (Month, Day, Year)

11/26/2007

State Registrar

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Medical

NOV 2 7 2007 DHMH 17 Rev 1/2001

29b. Signature and

itle of certifier

Elizabeth Fasika,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

575 Main Street Suite 351 Laurel, MD 20707 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Items Registrar	State of Mai 23b, 25 per	ryland / Depa me, g8/4	rtment of L tificate of	lealth and M Thb Death	lental Hygi	ene g. No 200	7 39849
	- L L L +		1. Decedent's Name (First, Middle, Las	t)				Date of Death Month		3. Time of Death
1	Physicia /Medic		ZENO WYETH HICKE	ERSON				NOVEMBER	205, 200	07 8:30A ^M
	Examin	er	4a. Facility Name (If not institution, give SOUTHERN MARYLAN	-		•	Location of Death		4c. County of Death PRINCE GEOF	
100	Funeral		Social Security Number 6. Se		(In yrs. last birthday).	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/10/19	Yea <i>r</i>) 9.	Birthplace (State or Foreign Country) KANSAS
60	Director		Usual Residence of Decedent		09			12/10/13	, , , ,	KANDAD
	arylan show d at	Ļ	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits XXYes 2 ☐ No
	the Ma 28a-f	Director	MD PRINCE 0	GEORGES	FORESTV	ILLE 10f. Zip Code		140	g. Citizen of Wha	
	with with the name of the name		7420 MARLBORO PI	KE		207	47	10	UNITED :	•
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V		Ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - /	American Indian,
36	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ※XXDivorced	1XXYes 2 ☐ No If Yes, Give Year or Dates: 1	AF	i Tes, specify Cuba	Specify:	nican, etc.)	Specify:	White, etc. BLACK
9	2 hour		15. Decedent's Ed	ucation	16a. Deced	ent's Usual Occup	ation	X 1	6b. Kind of Busin	ess/Industry
21215-0036	within 7 iene. • than "n the Medi	Completed	(Specify only highest grad	College (1-4or 5+) life. I	OO NOT use retired	during most of worki i)	ng		
121	filed w Hygier ther th		10TH 17. Father's Name (<i>First, Middle, Last</i>)		SU	PERVISOR	18. Mother's Name	(First Middle M	AIR FO	ORCE
Maryland	should be filed vand Mental Hygies marked other tumatic event, th	To Be	CLYDE HOWARD					EA DAVIS	aideil Sumame)	
ary	2 shoul and M is marl	F	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number,	City or Town, Sta	ite, Zip Code)
	d 2 th 2 7 is			STER		ELMHURST			HEIGHTS	, MD 20747
ore	Pages 1 nent of Ho nt: If iten iry or oth		20a. Method of Disposition XXX Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other plac	re)	Date 2	0c. Location - City	y or Town, State
Baltimore,			4 □ Donation 5 □ Other (Specify 21. Signature of Oneral Service License		MARYLAND Y					NHAM, MD
Ba	permit. Departr Importa any Inji		1 Stringle of Aller Solvies Electric	ull	MA 4.	ARSHALL'S 308 SUITL	ss of Facility FUNERAL AND ROAD	HOME OF SUITLA	MARYLANI AND, MD	D, INC. 20746
£ .	- S		23a. Part1 Enter the disease, or composing, or heart failure. List only of	lications that caused to one cause on each line	he death. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immedial Cause (Final disease or condition resulting in death)			tempirhay				
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Ľ.	D =	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	U	consequence of).		1 90	10	CAMINER	
	ecuter and transi	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C			Ow	MED BY MEDICAL E	Vg)	
8760,	icate be executed physician and sthe burial-transit	a E		Due to (or as a	consequence of):		CENTERATION APPE	D. VINCEN		
9	ifficate g phys	edical		d		20	ERIIII			
P.O. Box	he lav requires that the death certific te has t een signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pi 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date o Month	
S,	v requires that the de teen signed by the should be detached	y Pł	Part II. Other significant conditions co	0	,	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
ord	equire	ted k	cellulatis exit site	in how homy h	NSC			1 🗌 Yes	s 2 ⊡ No 3[☐ Probably 4 ☐ Unknown
Division or Vital Records,	has te	Completed by						24a. Was an autopsy perform	prio	re autopsy findings available r to completion of cause of th?
ta	(0 0		25. Was case referred to medical				26. Place of Death	1□ Yes 2	PNo 1□	Yes 2 No
Ž	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpatien	t 3 DOA Oth	or:	me 5 ☐ Resider		(Specify)
0 _	ng Ph (fter th Ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. Time of Injury	28c. Injur Wor		28d. Describe how		
sio	ttendi Jeath. stor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of injur	y - At home, farm, stre		Yes 2 □ No	Of Lagring (Str	and Alumbas	Purel Boute Muselon
Ω	al or A s after Il Direc	Certification:	4 Homicide determined	building, etc.	(Specify)	set, factory, office	1	City or Town,		or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 2 Metifal Exam	vsician: To the best of liner: On the basis of e and manner state	examination and/or inv	occurred at the tir restigation, in my c	ne, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	To th To th COMP	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (A	Month, Day, Year)
	(A)		Nah		M	10005	120		Nov 6	2007
	(5)		30. Name and address of person who can have the same that		ath (Item 23a) (Type, I on Avenue (10 War	hungton	De wo	3>
	Sta		31. Date filed (Month, Day, Year)	32. Registrar				J		
	Registr	ar∍	DEC 0 7 2007	Bleever	1 Sound	4				

DHMH 17 Rev 1/2001

ORIGINAL

Amend Items 23,27,28a-f per me a Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROBERT HENRY HOFFMAN III 2007 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Oate of Birth (Month, Day, Year)

Months Days Hours Min. December 7-26, MASHINGTON COUNTY WASHINGTON 6. Sex 1X M 2□ F Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Georgia 228-96-8897 Director 34 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Three Springs 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 🏖 No Pennsylvania Huntingdon Three Springs Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o USA 17264 21698 Dug Hill Road rai", or items 23a Examiner must b Pages 1 and 2 should be flied within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1♥↓₹es 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: er than "natura the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disable Never Worked 12 item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beverly Shope Robert H. Hoffman, Jr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Hoffman (Mother) 21698 Dug Hill Rd., Three Springs, PA 17264 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 27, 2007

Indiantown Gap National Cemetery Annville, Pennsylvania 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc. 21. Signature <u>M-00849</u> hotam 48 S. Church Street, Waynesboro, Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOVASCULAR COLLAPSE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CERTIFICATION NEPROVED BY MEDICAL EXAMINER SEPSIS Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine MALNUTRITION attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, DECUBITUS vuo Physician/Medical BUTTOCK IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No QUADRIPLEGIA 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No INSULIN DEDENDENDENT DIABETES MELLITUS 24a. Was an page 2 s autopsy performed certificate 1∐ Yes 2 No Division or Vital the Hospitalior Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 200 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Subject Medical Certification: Vatural Injury 5 Pending Unknown • Passenger in pickup truck that investigation 11/1993 1 ☐ Yes 2 ☑ No 2 Accident 20 Cocaton Street and Number or Rural Route Number 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide Roadway Spearman, Texas 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who complete cause of death (Item 23a) (Type, Print) 11/22/2007 D0038466 JEY E. ANTIETAM ST. ARYEN C
31. Date filed (Month, Day, Year) HERRERA 21740 L . Registrar's Signature State DEC 0 7 2007 Registrar market

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year John Gonzie Knott December 3, 2007 4:15 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1XM 2□ F 59 212-56-0222 06/26/1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20650 18881 Hodges Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Merchant Seaman</u> <u>Shipping</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Harvey Knott Donnie Marie Slade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Knott/Brother 45210 Medley's Neck Road, Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 12/08/2007 | Charlotte Hall, MD 21. Signature of puteral Service License Edward N. Brinsf 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturai", or items 23a or any injury or other traumatic event, the Medical Examiner must be a

Maryland 21215-0036

Baltimore,

Director

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Completed

Be

Examiner burial-trar attending physician for use as the buria Physician/Medical ate has been signed by the page 2 should be detached þ Completed Be Certification: To this To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

W B

Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical	26. Place	of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nur.	sing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ N	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and niner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b/Signature and title

and address of

erson who completed cause of death (Item 23a) (Type, Print)

Maresh Malik, M.D. 25500 Point Lookout Road, Leonardtown, MD 31. Date filled (Month," Day, Year) 32. Registrar's Signature

LOGAN

KATHLEEN

Registrar

DHMH 17 Rev 1/2001

2007

DEC 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend#23B per PHY State of Maryla State of Maryla Registrar 11/27/07 AACO HFALTH DEPT CMH 39856 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:03P M 11/16/2007 Ernest George Malchodi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days **X**XM 2□ F 89 New York 08/25/1918 Director 110-05-3948 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Directo Maryland Bowie Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō be 20715 U.S.A. 12109 RoundTree Lane 7 Is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must to Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 42-46 within 72 hours after 1 ☐ Never Married 2 → Married White 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. 7 Is marked other than "I IRS Elementary/Secondary (0-12) College (1-4or 5+) Tax Liasion Specialist Internal Revenue Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Piva Charles Malchodi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is rr any injury or other traurr once. Marie Malchodi 12109 Round Tree Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 11/21/2007 Crownsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home Willi 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** sephic /Medical Due to (or a la consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760; IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 Is No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 🖍 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 45660 pointer single, 124 Bacie and addre

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 7 2007

32. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>		te of D			Reg. No.	2007	39	357	
			1. Decedent's Name (First, Middle, Last	†)					2. Date of De	ath Day	Year	3. Time of	Death	
lain.	Physici /Medic		Margaret Jea	McCloskey				Novemb	er 26	2007	7:20	ам		
	Examin	er	4a. Facility Name (If not institution, give	street and number)				ocation of Death.		4c. 0	County of Death			
			The Gabriel Home 5. Social Security Number 6. Se	(In yrs. last birthday,		ver Sper	pring If Under 24 Hrs.	8. Date of Bir		Montgomery		r Foreign		
l	Funeral Director	Funeral Director		_M 2 🔀 F 85	Vrs	Months		Hours Min.	June 27	ıy, Year)	Cou	olace <i>(Stat</i> e o ntry) ISY1var		
	the Maryland 28a-f show otified at		10a. State 10b. County 10c. City, Town or Location 10d. Insi										ity Limits	
			Maryland Mo	ntgomery	Silve		ring ip Code		1	10a Citiz	en of What Cour			
	with ya or t be r	Ö	12805 Tamarack F	b.c.o.		701.2	20904				JSA	,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Jera	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Dec		panic Origin? (Sp , Mexican, Puerto	pecify Yes or No		4. Race · Americ			
21215-0036		by	1 ☐ Never Married 2 ☐ Married 31 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:			21 No		o Alcan, etc.)		Black, White, Specify:Whit			
		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ir								dustry			
212		mo	12	College (1-40r 5+	Homen	naker				Owr	1 Home			
		Be C	17. Father's Name (First, Middle, Last)				1	18. Mother's Nam	e (First, Middle	, Maiden S	Surname)			
Maryland		То	Joseph Savannah		1			Margare						
Mar			19a. Informant's Name/Relationship (T)	,				nd Number or Ru				,		
Baltimore, I			Teri Ann Emig/Da 20a. Method of Disposition	ugnter	20b. Place of Disp			ack Road	Date		ation - City or T		t	
			XX Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		Gate of F	leave	n Ceme	etery 2	007		er Sprin	ıg, Mar	yland	
			21. Signature of Funeral Service Licens	See Qu				of Facility Collins sity Blv				a MD	20001	
	Physician /Medical Examiner	Examiner	23a. Part1. En ir the disease, or comp	lications that caused to	le death. Do not er	iter the m	ode of dying	, such as cardiac	or respiratory a	rrest,	r_sprin	Approximat	te	
la ·			23a. Part1. Ern r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Years											
			resulting in death)		consequence of):							1.6	ears	
10			Sequentially list conditions,	b										
)			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.											
,	execunate and al-tran	Exar	that initiated events resulting in death) Last Due to (or as a consequence of):											
68760,	tificate be executed g physician and as the burial-transit	edical		d										
	ag ag		IE EE MALE											
. Box	death cert e attendin d for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death 3	□Ectopic □ Other (pregnancy specify)			2	3d. Date of deliv Month	-	Year	
P.0	at the de by the a	2hys	9 ☐ Unknown			00 811								
Records,	quires that in signed k uld be det	by	Part II. Other significant conditions of	ontributing to death but	cause giver	n in Part I.		e. Did tobacco use contribute to the cause o 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 [
O O	The law requires that the death cer pate has been signed by the attendin page 2 should be detached for use	Medical Certification: To Be Completed							24a. Was		24b. Were auto prior to co	opsy findings	available	
E E									perf	ormed? 2 X No	death?		ause of	
Vital	sician: Th certificate rector, pag		25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)				
or V	After this uneral dir		1 ☐ Yes 2 ∑XNo	Hospital: 1 ☐ Inpatien				4 LI Nursing H			☑Other (Speci	fy)Group	Home	
ou c			27. Manner of Death 1 Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. Time (or M	28c. Injury Work?	at ? es 2 □ No	28d. Describe	now injury	occurred			
.=	or Attenter death iter death inector:		2 Accident investigation 3 Suicide 4 Homicide determined See Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)								al Route Nun	nber,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier (Check only (Ch										s)	
	the I		one) and manner stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	N N N	-	Zab. Signature and little of certifier	14/1			34032	Hallioti			ovember		2007	
	5		30. Name and address of person who d	-V/0	ath (Itam 22at (Trina									
			Jeanne P. Asher,		Farragut		ue, Ke	ensingto	n, MD 2	0895				
2	Sta Begistr		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	make !								

P.O. Records, Division or Vital To the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: 0

> State Registrar

29b. Signature and title of certifier

30. Name and address of person

6

who completed cause of death (Item 23a) (Type, Print)

29c. License number

D00060756

WMOis St. Elkbon,

29d. Date signed (Month, Day, Year)

Fui Dire

		Please	Type or Prin						-		_	ie.				
	1 - For State Registrar			, , , , ,		rtificate				Reg. N	0.0	0.7	30	125		
cian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year NOVEMBER 23, 2007 5:09 A M															
lical			e street and number)		_	4h City Toy	wn orlo	ocation of Death	NOVEMI	MBER 23, 2007 5:09 A M						
iner			D HOSPITAI				PRINCE GEORGES									
ı	5. Social Security	Number 6. S		7. Age (In yrs. last birthday)			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.						place (State	or Foreign		
r	214-15-9 Usual Residence of	037	X	34 Yrs. Solve Solv					10/01/1973 MARYLAND							
	10a. State	10b. County		10c. Cit	y, Town or Lo	cation		10d. Inside City Limits								
Director	MD	PRINCE	GEORGES						1 Ares 2 No							
Dir	10e. Street and Nu	umber D Y GLEN TE	DDACE			10f. Zip Co	\	10g. Citizen of What Country? UNITED STATES								
Funeral	11. Marital Status	OI GLEN IE	12. Was Decedent	2. Was Decedent Ever in U.S. 13. \			20743 Was Decedent of Hispanic Origin? (Speci				14. Race - American Indian,					
/Fur	1 📉 Never Mai	rried 2 Married	Armed Forces? 1 ☐ Yes 2 📉 If Yes, Give	1 ☐ Yes 2 M No If Yes, Give Year or Dates:			If Yes, specify Cuban, Mexican, Puèrto Rican 1 ☐ Yes 2 ☑ No Specify:				Black, White, etc. Specify: BLACK					
d by	3 Widowed	4 Divorced	Year or Dates:				edent's Usual Occupation				16b. Kind of Business/Indus					
plete	(Spe	ecify only highest gra	ade completed)	completed) (Give ki			kind of work done during most of working OO NOT use retired)									
Completed	9	oligary (0*12)	College (1-401)	DRIVER					TRANSPORTATION							
Be		(First, Middle, Last • WASHING			18. Mother's Name (First, Middle, Maiden Surname) BARBARA CLAUDETTE MARSHALL WASHINGTON											
T ₀	19a. Informant's N	Name/Relationship (Type. Print)		19b. Mailir	g Address (S	treet an	d Number or Ru	ıral Route Num	ber, City	or Town, S	tate, Zip	Code)			
	LINETTE	MARSHALL/	SISTER		7323	SHADY (GLEN	TERRAC	E, CAPI	TOL	HEIGH	TS,	MD 20)743		
	20a. Method of Dis 1 ☐ Burial 2		Removal from State		Place of Dispo cemetery, crei	natory or othe	r place)	montr Moss	Date		Location - C	•				
	1 Burial 2 Micromation 3 Removal from State 4 Donation 5 Other (Specify) BRINSFIFID—FCHOIS CREMATORY NOV. 29, 2007 CHARLOTTE HALL, MD															
	21. Signature of Funeral Service Meense J. J. LYDIA C. THORNTON JOHNSON 111. OKNITON FUNERAL AHOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640															
sal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):															
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown										23d. Date of delivery Month Day Year					
Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba									tobacco	acco use contribute to the cause of death?					
												B ☐ Prol	bably 4]Unknown		
Completed	24a. Was an autopsy										24b. Were autopsy findings available prior to completion of cause of					
										performed death? 1 Yes 2 No 1 Yes 2 No						
o Be	25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residual Resi									sidence 6 ☐Other (Specify)						
on: To	27. Manner of Dea		28a. Date of Inju	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No					28d. Describe how injury occurred							
Certification:	2 Accident 3 Suicide 4 Homicide	investigatio	e 28e. Place of inj						28f. Location (Street and Number or Rural Route Number, City or Town, State)					mber,		
Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 27 07															

State Registrar DHMH 17 Rev 1/2001 AMIT SURI, M.D.,
31. Date filed (Month, Day, Year)
NOV 2 8

2007

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735

32. Pygistrar's Signature 20735

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 17110 M Physician ber 23,207 L. NICHOL Novem /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL CALVERT MANOR HEALTHCARE CENTER RISING SUN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TF 101 195-07-7132 08/11/1906 PENNSYLVANIA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 1 ☐ Yes 2 No DE **NEW CASTLE NEW CASTLE** Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or: 23 BUNKER HILL RD. 19720 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 th No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Baltimore, Maryland 21215-0036 WHITE Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.

Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORES SALES CLERK 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ROHRBACH HECK ၉ 19a. Informant's Name/Relationship (Type PAUGHTER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANETTE C. NICHOL/ IN- LAW 23 BUNKER HILL RD. NEW CASTLE, DE 19720 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 3 ☐Removal from State MAYERDALE CREMATORY 11/28/2007 NEWARK, DE 4 ☐ Donation 5 ☐ Other (Specify) Fu da Service Lice 22. Name and Address of Facility SPICER-MULLIKIN INC. 1000 N. DUPONT PKWY. NEW CASTLE, DE 19720 Approximate Interval Between Onset and Death , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No page 2 s this certificate 1 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) or Attending 1 A Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 164-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ss of person who completed cause of death (Item 23a) (Type, Print) 133 N. Bridge St. ElkTon, MD lasons as iled (Month, Day, 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

07-09053 David E. Odge Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vid E. Odger	1	1- For S		ate of Mary	/land /	Depar Certi	tment of ificate of	Health a <i>Death</i>	and M	ental H		eg. No.	20	07	3986
Physicia		Registr 1. Dec	ar edent's Name (First, Middl	e,Last)							2. Date of Dea Month Novembe	th Day	Year	3. Time of 0729	
edical Exami	ner	Da	vid E.			0dge	r	b. City, Towr	2 05 1 000	tion of Deat		r 23, 2	2007 c. County of Death		
*			cility Name (if not institution		I number)		14	Clinton	i, or Loca	tion of Beat		F	Prince George	e's	
			outhern Maryland Ho	6. Sex	7 Ans	e (In yrs. las	st birthday)	If Under 1	Year If	Under 24Hr	s. 8. Date of Bi	rth (MM	/DD/YYYY) 9. Birt	thplace (Sta	ate or
Funeral Director	ŀ		al Security Number			47	Yrs		Days I	Hours Min	June	13,		untry) Cł	nile
Director			9-51-4977 Residence of Decedent	1X M 2		47		<u> </u>						40d Incid	e City Limits
iny		10a. S				10c. City,	Town or Locati	on							s 2 X No
id how a	ڀ	Vir	ginia Loud	on		Sou	th Rid					10 0	tizen of What Cou		
ne Maryland or 28a-f show any fifed at once.	Director	10e. S	Street and Number					10f. Zip Co]		ile	iitu y :	
5-0036 ed within 72 hours after death with the Maryland tygien. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Öİ	253	373 Crossfie	lds Driv	re			2015			C-seifu Vos os N		14. Race - Ame	rican Indian	, Black,
with ms 23	Funeral	11. M	arital Status	12. Was	Decedent	Ever in U.S	S. 13. Wa	is Decedent es, specify (of Hispan Cuban, Me	ic Origin? () exican, Puer	Specify Yes or N to Rican, etc.)	1 0-	White, etc.		
r death or ite	Ē		Never Married 2 X	vorced If Yes, Give	es 2	XNo	1 X	Yes 2	No si	pecify: C1	hilean		Specify: Whi	te	
s after ral",	b S		Widowed 4 Di Decedent's Education (Sp			npleted)	16a Docede	at's Usual Oc	cupation	(Give kind o	of work done	16b	. Kind of Business	/Industry	
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d with	Completed	17. F	ather's Name (First, Middl	e, Last)							me (First, Middle		en Surname)		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", event, the Medical Examiner.	Be	Le	opoldo Odgei				10h Mailir	a Address	(Street at	mella	Contre	lumber,	City or Town, Sta	te, Zip Cod	e)
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MD nd 2 sho alth and m 27 is	1	200	wena A. Evan			200.	Place of Dispo	sition (Name	of cemet	tery,	Date		c. Location - City	or Town, St	ate
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Baltimore, permit. Pages I at Department of Hee Important: If ite		4	Donation 5 Other	Specify:		Fa	171ax F	Name and A	ddress of	Facility	Funera				
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Physicia	_	23a.	Part I. Enter the disease,	or complications	that cause	ed the death	n. Do not enter	the mode of	dying, su	ich as cardia	ac or respiratory	arrest,	shock, or heart		ximate Interval een Onset and
✓ -/Medica		1	failure. List only one cau	se on each line.											Death
amine	r	orc	ediate Cause (Final disea ondition resulting in death			sequence	of):								
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	196	if ar	iy, leading to immediate se_Enter Underlying Cau	se 📜	or as a cor	isequence	01).								
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r 68 certif	use as	Clar	past 12 months?	4		at time of		Other (Spec	cify)			- 1			
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O. lat the	etache	Par	t II. Other significant co	nditions contrib	uting to de	eath but not	t resulting in tr	ie underlying	cause gr	ven in rait.			2 No 3		
B, P	d be d											Was an		e autopsy f	indings available
ords v requ	shoul	Completed									- _	autopsy perform	ed? deat	th?	ion of cause of
ecc he lay	age 2	팅										Yes 2	No 1	Yes	2 No
an: T ertific	ctor, p	ව මේ ^{25.}	Was case referred to me examiner?								heck only one) Nursing Home	5 R	esidence 6	Other:	
Vita hysici this c	dire	0	1 ✓ Yes 2 No	Hospital			✓ ER/Outpat		, , , , , , , , , , , , , , , , , , ,	y at Work?	28d Desc	cribe ho	w injury occurred		
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death. "I birector: After this certificate has been signed by	y the	Certification:		rending			t home, farm,	street, factor	y, office b	uilding, etc.	28f. Loca	tion (St	reet and Number	or Rural Ro	ute Number, City
ivis lor A after Dire	dinb	≝ ₃	Salcide	Could not be		Local St					NB Old E	own, Sta Branch	ate) Avenue, Clinto	n, Md.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ly fille		Homicide					ccurred at th	e time, da	ate and place	e, and due to the	e cause	(s) and manner as	s stated.	oo(e)
the Horin 24 the Fu	npletel	Medical	heck only 1 ☐ CertifyII e) 2 ✓ Medical	Examiner: On the	e basis of	examinatio	n and/or inves	tigation, in m	y opinion	, death occu	urred at the time,	, date a	,		se(S)
To the within To the	con	29 29	b. Signature and title of co	and n	nanner sta	icu.			c. Licens	e number			29d. Date signed	(Month, D	ay, Year)
6			llelyonte	Thel	16.1	(O.C.	M.E.			November 2	4, 2007	
		30	. Name and address of pe	erson who comple	eted cause	of death (I	tem 23a)			111	MD 04004				
	-		Margarita Korell M		nt Medi	cal Exar	niner 11	1 Penn S	treet, B	aitimore,	MD 21201				
		ate 3°	. Date filed (Month, Day)	8 2007	324Reg	istrar's Sig	nature	and of							
Re	gisti	rair	110 4 %	- 2001		September .	And head	-						OCME	

			For State of Ma State Registrar		artment of Health and N <i>rtificate of Death</i>	lental Hygier Reg. t		39862
	D1		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
-	Physicia Medic/	_	ARLIE PHILLIP PINDER			NOVEMBER	21 2007	11:04 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death EASTON	1	4c. County of Death ምልፕ	BOT
	Funeral		201 FEDERAL ST., APT. 86 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign ntry)
	Director		214-32-0724 X M 2 F	78 Yrs.	Months Days Hours Min.	(Month, Day, Yea	1928 MAR	YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	Maryla f sho ied at	ō	MD TALBOT	EAST	CON			1 X Yes 2 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
	th with	alD	201 FEDERAL ST., APT. 86		21601		USA	
	tems	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No. 1 Yes 2 No. 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	1 ☐ Yes 2 📉 No Specify:		Specify: WH	ITE
5-003	72 hou natura iical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of work		. Kind of Business/Ir	ndustry
2121	ithin 7 ne. nan "r e Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+	+) life. L	DO NOT use retired)			
7	filed within Hygiene. Ither than "	S	6 0	A3	TTENDANT 18. Mother's Nam	e (First, Middle, Maid	HOSPITAL den Surname)	
and	hould be filed id Mental Hygi marked other matic event, t	To Be	ERNEST PINDER			E MAE CHAN	,	
Maryland	should be and Mental smarked o	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Number or Rui	ral Route Number, Cit	ty or Town, State, Zi	ip Code)
	es 1 and 2 should b of Heath and Ment Fitem 27 is marked r other traumatic e		ELLEN PB. PINDER/SISTER-IN-		FEDERAL ST., APT			
Ore	Pages 1 nent of Hu int: If iten iry or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State		matory or other place)		. Location - City or T	
altimore,	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		MEMORIAL PARK 11, 2. Name and Address of Facility	/28/2007	EASTON, M	IARYLAND
Ba	permit. Page Department Important: Il any Injury o		JOHP R. MERCE!	FEI	LLOWS, HELFENBEIN	& NEWNAM	FUNERAL H	IOME PA
	515-5		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,	21001	Approximate
	Physician		Immediate Cause (Final disease or condition		CULTR INSJEF	FICIFING	-1/	Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a	a consequence of):		1		8 vame
k		e	Sequentially list conditions, b. Du to (or as a	a consequence of):	10 N			دعا العارد
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Ö,	e exectan an an an an an an an an an an an an a		that initiated events resulting in death) Last	a consequence of):				
58760,	ficate be executed physician and sthe burial-transit	edical	d					
_	death certific attending pl		IF FEMALE: 23c. If yes, outcome page 23c. Was decedent pregnant 23c. If yes, outcome page 23c. If yes, outcome 23c. If yes,			-	23d. Date of deliv	very
P.O. Box	The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1		□Ectopic pregnancy □ Other <i>(specify)</i>	· · ·	Month	Day Year
Ö	N requires that the diplement signed by the should be detached	hys	9 ☐ Unknown					
_	res that	þ	Part II. Other significant conditions contributing to death bu	it not resulting in the u	nderlying cause given in Part I.	1 ☐ Yes	co use contribute to 2 No 3 Pro	the cause of death? bbably 4 Onknown
Records,	requi	Completed	SPINAL ST	Talce /		24a. Was an		topsy findings available
Š	stcian; The law certificate has birector, page 2 s	ldwo	3111111231	1710317		autopsy performed	prior to c death?	ompletion of cause of
Vital	stcian: T certificate rector, pa	Be Co	25. Was case referred to medical		26. Place of Dea	1 Yes 2 ☐ th (Check only one)	No 1 ☐ Yes	2 a No
>	Q №	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatier			ome 5 🛚 Residence	e 6 □Other (Spec	cify)
n o	ding Pl		27. Manner of Death 28a. Date of Injur 1 ☑Natural 5 ☐ Pending (Month, Day		Work?	28d. Describe how is	njury occurred	
Division or	or Attending Physician: after death. Director: After this certifica in by the funeral director, I	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju	ıry - At home, farm, str		28f, Location (Street	t and Number or Ru	ral Route Number,
<u>S</u>	alor A safter Il Dire	Certification:	4 ☐ Homicide determined building, etc	:." (Specify)		City or Town, S	tate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only (C	examination and/or in				
	thin 2 the lothe lomblet	Med	one) and manner sta 29b. Signature and title of certifier	ted.	29c. License number	29d.	Date signed (Month	h, Day, Year)
	F ≯F ŏ		. c. ww. Brin		D0000 25	0	11/21/	07
	3		30. Name and address of person who completed cause of de			ю I—		-/
			31. Date filed (Month, Day, Year) 3. Registra	BA1 N	9704 BANTRY	140AD , DA	IS TON, IZ	D, 21601
	Sta Registi		NOV 2 6 2007	ar's Signature	We /			

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	Eas.	State of Maryland / Department of Health and Mental	Hygiene
1-	For State	Certificate of Death	Box No 2 1

			For State	State of M	aryland /	-	artment of H <i>rtificate of L</i>			giene leg. No	2007	39863
7			Registrar 1. Decedent's Name (First, Middle	le, Last)		001	tinoato or E		2. Date of Dea	ıth		3. Time of Death
	Physicia			STINE PALMIS	ANO				Month NOVEMBE	R 2	0 2007	7:45PM M
	/Medic Examin		4a. Facility Name (If not institutio				4b. City, Town, or	Location of Death	PIO VELIBER		County of Death	7.45111
	3	Ĭ,	7204 BOGLEY	ROAD, UNIT	102		BALTI	MORE			BALTIM	ORE
20	Funeral		5. Social Security Number		ge (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year)	Coui	olace (State or Foreign
	Director		220-52-4548	1 E3 IVI 2 1	56	Yrs.			JAN 16	,195	1 MARY	ZĽAND
	and w	}	Usual Residence of Decedent 10a. State 10b. County	/	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Maryl f sho	Ď	MD BALT	TIMORE		RΔT	TIMORE					1 □ Yes 2X No
	r 28a	Director	10e. Street and Number	HIORE		DELL	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	th with	a D	7204 BOGLEY R	OAD, UNIT 10	2		212	244			USA	
	ems ar mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp.n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	1	4. Race - Ameri Black, White,	
0	s after , or it	by Fu	1 X Never Married 2 Mar	If Yes, Give	No		1 ☐ Yes 2 💢 No				Specify:	COSTO
5	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced	nt's Education	16	a Deced	dent's Usual Occupa	ation		16b. Kir	MH]	
7	in 72 n "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or		(Give	kind of work done of DO NOT use retired	during most of work	king			,
7	filed within Hygiene. ther than '	E O	12	1	5+)		DELIVERY			R	ESTAURAN	NT
ב פ	othe vent,	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Middle,	Maiden :	Surname)	
<u> a</u>	should be nd Mental marked c	To E	AUGUSTINE P.	ALMISANO III				DORI	S LEE			
<u>a</u>	2 should be filed w and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relations				ng Address (Street a					
s` (1)	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		DORIS L. RUNG	E/MOTHER			S8 HICKORY		ROAD, EA		, MD 216	
0	Pages nent of the int: If ite		20a. Method of Disposition Burial 2 Cremation		cemei	tery, crei	matory or other plac	e)				
Daitim	it. Partmen		4 □ Donation 5 □ Other (3		WOODL		MEMORIAL 2. Name and Addres		2//2001	EAS	TON, MAI	RYLAND
מ	permit. Page Department of Important: If any Injury or once.		JOHN F	3. MERCI	ERON	$\int \frac{F}{2}$	FELLOWS, H	HELFENBEI RRISON_SI	N & NEW	NAM MD	FUNERAL 21601	HOME PA
ı			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause st only one cause on each I	d the death. Do	o not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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f	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	terolo	/				107000
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	rted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	₹ 2000	u 001100qu0110	,-						
	execun and ial-tra	Examiner	resulting in death) Last	C Due to (or as	a consequenc	e of):						
2/00	icate be executed physician and s the burial-transit	edical		d								
0	certifica nding ph		IF FEMALE:									
X O D	death certific e attending p ed for use as t	ian/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal dea		Ectopic pregnancy	,		2	23d. Date of deliv Month	rery Day Year
- -	the de ny the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death	5L	Other (specify)					
ī,	that ed b deta		Part II. Other significant condit	tions contributing to death t	but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
	requires een sign nould be	d by							1 🗆 1	res 2[□ No 3 Rero	bably 4 Unknown
ecords	law rec as beer 2 shou	Completed							24a. Was		24b. Were aut	opsy findings available
Ť	e ž e	от								rmed? 2. ₩₩Ño	prior to death?	ompletion of cause of 2 □ No
VII	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	al				26. Place of Dea	ath (Check only o			
0	hys l dii	To	1 Yes 2 No		ient 2□ER/0	<u> </u>		4 Li Nursing H	lome XX Resid			ify)
	ding Ph n. After th funeral		27. Manner of Death 1 ★Natural 5 ☐ Pendi	28a. Date of Inj (Month, Da		o. Time o Injury	Worl		28d. Describe h	now injur	y occurred	
JIVISION	ttend death stor: ,	icati	3 Suicide 6 Could		iury - At home.	farm, str	M 1 ☐	Yes 2 □ No	28f Location (5	Street an	d Number or Ru	ral Route Number,
2	lor A after Direction by	Certification:	4 ☐ Homicide determ	mined building, e	tc. (Specify)		,,,		City or Tov			
	spita nours neral y fillec			ing Physician: To the best								
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical	(Check only 2 Medica one)	al Examiner: On the basis and manner s		and/or in						
	To t To t	Σ	29b. Signature and title of certifi	er Mo			29c. Licens	e number	1		e signed (Month	
								- 111)		(/		/
	5		30. Name and address of person JORGE H. ABRE					NT 21	1601			
	Sta	te										
	Registr		NOV 26	2007 2007	15	400						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4a. Facility Name (If not institution, give street end number) 0) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Bi Hours Min. (Month, De 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Days 220-14-9421 84 Director February 14, 1923 Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "neture!', or items 23e or 28e-f show event, the Medical Everginer must be notified at 1 TYes 2KINo Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21955 Pegg Road 20653 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse G. Grover Ella F. Abell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 46033 Strickland Road Donald Strickland / Nephew Great Mills, MD 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State December injury or Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens mportant: 7, 2007 22. Name end Address of Facility 21. Signature of Funeral Service, Licenses Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 o, or complications that caused the ceath. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one ceuse on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) el u Examiner Due to (or as e consequence of) Examiner attending physician and for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical Due to (or as a consequence of): resulting in death) Last signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has been si lirector, page 2 should Ischema H Been 1 ☐ Yes 1 ☐ Yes 2 ☐ Ne or Attending Physicien: efter death, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: AUNursing Home 5 Residence 6 Other (Specify) ို 21 No 1 ☐ Yes After this the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Waturei 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3
Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a, Certifier and menner steted. To the within 2 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certification 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 100

DUMBIL 46 Day 640

State Registrar ZAA7

			For State		State of Ma	arylan						lental H	lygien	е		
			Registrar 1. Decedent's Name (F	First Middle Last	1		Cei	rtifica	te of I	Deati	<i>n</i> ────	2. Date of	Reg. N	<u>~200</u>	7	39865
	Physicia		Eugene	,		D = l						Month		ay Ye 2007	ar	8:35P M
	/Medic Examin		4a. Facility Name (If no			RODE	erts	4b. City	Town, or	r Location	n of Death	11		c. County of D	eath	0:33P
			Talbot	Hospid	e House			E	asto	na				Tal		
	Funeral		5. Social Security Num	10	7. Age		last birthday) Yrs.	If Unde Months	r 1 Year	If Under	er 24 Hrs. Min.		Day, Yea	r) 9.		ace (State or Foreign (ry)
	Director		218-20-7 Usual Residence of De			80						09-0	1-19	27 M	1.	
	nyland how at			b. County		10c. City	y, Town or Lo	cation							10	Od. Inside City Limits
	e Ma Ba-f s	cto		Talbot		1	Easto						1			1 X Yes 2 No
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 114 Glen		ve.			10f. Zi	p Code 2	2160	1		-	citizen of What SA	Count	try?
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	, ,	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 ☐ Yes	,	lispanic (an, Mexid Specia		ecify Yes or Rican, etc.)	No-	14. Race - A Black, V Specify:	/hite, e	etc.
ה ה	72 hour		15	i. Decedent's Edu only highest grad	cation		16a. Dece	dent's Usi	ial Occup	ation during m	ost of work	ing	16b.	Kind of Busine		
7 7	d within giene. rr than ' the Me	Completed	Elementary/Seconda	ary (0-12)	College (1-4or 5	+)	life.		ise retired init				S	unTru	st	Bank
ב פ	d be file antal Hy ed othe	Be	17. Father's Name (<i>Fir.</i> Barttlet		Robe	rts					ther's Name eanet			_{en Surname)} illiar	ns	
7	should nd Me mark matic	으	19a. Informant's Name				19b. Maili	ng Addres	s (Street					or Town, Sta		Code)
M.	and 2 salth a 27 is		Martina	Roberts	s / wife		114	Gle	nwo	od i	Ave.	East	on,M	d.216	01	
ב ב	of He		20a. Method of Disposi		Removal from State	l c	Place of Dispo	osition (Na matory or	me of other plac	ce)	Ī	Date	20c.	Location - City	or To	,
	tπent tant: tant:		4 □Dopation 5	Other (Specify)		Mo	d. Ve							rlock		
ם ם	permit Depar Impor any In once		21. Signature of Fune	ral Service Licens	tork			2. Name a			Бе			th Fur Md.2		al Home)1
				ailure. List only o	ne cause on each lir	ne. /			de of dyir	ng, such	as cardiac	or respirator	y arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fin disease or condition resulting in death)	al e	Due to (or as		Cancer	K							1	tmmths
	Examiner		Paguantially list condit	riono I)	a conseq.	40.100 017.									
	sit sed	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju	ediate ng	Due to (or as	a conseq	uence of):									
	icate be executed physician and s the burial-transit	хаш	that initiated events resulting in death) Last		Due to (or as	a conseq	uence of):								+	
Š,	e be e sician	edical E		· ·	4	·										
00	tificate ig phy as the															
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	death 3	□Ectopic □ Other (s		у			-	23d. Date of Month		ry Day Year
, ,	s that t ned by e detac	by Ph	Part II. Other significa	int conditions co	ntributing to death bu	ut not res	ulting in the u	nderlying	cause giv	en in Pa	rt I.	23e. D	id tobacco	use contribu	te to th	e cause of death?
coins,	equire een sig ould be											1	□Yes	22€40 3[] Prob	ably 4 ☐Unknown
ב ב	has be	Completed							_			24a. W	as an utopsy erformed?	prior	to cor	psy findings available npletion of cause of
Ģ	n: Th ficate or, pag		25. Was case referred	to modical						00 51		1□ Ye	s 2 2 1		Yes	2 0
>	/sicla	To Be	examiner?		Hospital: 1 ☐ Inpatie	ent 2□	ER/Outpatie	nt 3□ D	OA Oth	or:		n <i>(Check or</i> me 5□ F		6 Other /	Specifi	, hopice
5	ig Phy ter thi neral o		27. Manner of Death	5 ☐ Pending	28a. Date of Inju	ry	28b. Time o		28c. Injur Wor					jury occurred	500011	, , , , , , , , , , , , , , , , , , , ,
	endir eath. or: Af the fur	atio	2 Accident	investigation 6 ☐ Could not be				М	1 🗆	Yes 2						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of injubulding, etc	ury - At ho	ome, farm, st y)	reet, facto	ry, office				n (Street Town, Sta		r Rura	I Route Number,
	e Hospii 24 hour e Funer letely fill	Medical (sician: To the best of ner: On the basis of and manner sta	f examina										
	To th within To th comp	Me	29b. Signature and title		0 100			25	c. Licens	e numbe	er		29d. [Date signed (N	lonth,	Day, Year)
	11		Male	then Fir	eks NID	,			05	225	3 /			11-2	7-	07
14	AVA		30. Name and address	of person who co	ompleted cause of de	eath (Item	04Rt	Print) East	n /	May	land	216	0/			
	Sta Begistr		31. Date filed (Month					and the								

DHMH 17 Rev 1/2001

			For 1 _ State	State	of Ma	arylan						lental Hy	giene	•	
		4	Registrar 1. Decedent's Name (First, Midd	la last)			Cer	tificate	e or i	Deati	7	2. Date of De	Reg. No.	2007	39865
	Physici		John Bernard		16.	Sr.						Month Decemi	Day	1, 2007	1:31 A _M
	/Medio		4a. Facility Name (If not institution			DI •		4b. City,	Town, o	r Location	of Death	Docom		County of Death	1
			St. Mary's H	osptial				1	Leon	ardt				St. M	ary's
	Funeral		5. Social Security Number	6. Sex 1X M 2 ☐ F	7. Ag	e (In yrs. I 68	ast birthday)	If Under Months	1 Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth Cou	place (State or Foreign intry)
	Director		219-36-8302 Usual Residence of Decedent	163111 201		00	Yrs.					August 2	27, 19	939 Mar	yland
	land ow		10a, State 10b. County	,		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary I-f sh	ţoţ	Maryland Maryland	St. Mary's					Le	onard	town				1. Yes 2 □ No
	ith the Marylan or 28a-f show e notified at	Director	10e. Street and Number			1		10f. Zip					10g. Citi	izen of What Cou	ıntry?
	23a cust b	a	22519 Point Looko	ıt Road					20	650				USA	
	er dea items	Funeral	11. Marital Status	12. Was Dec	orces?		S. 13. V	Vas Deced f Yes, spec	dent of H cify Cuba	lispanic C an, Mexic	origin? (Sp an, Puerto	ecify Yes or No Rican, etc.))-	 Race - Amer Black, White 	
36	rs after	by F	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes. G	iive -	NO	1	I □ Yes	2⊠ No	Specif	y:			Specify: B	lack
٥	2 hou atura cal E	ted	15. Decede	nt's Education			16a. Deced	lent's Usua	al Occup	ation			16b. Ki	ind of Business/I	ndustry
715	ihin 7: an "n Medi	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed College		5+)	(Give life. L	kind of wor OO NOT us	rk done se retired	during mi d)	ost of work	ang	Mary	yland Stat	e Highway
2	ed wil	Completed	8			,	Driv	er					<u> </u>		
2	be file	Be	17. Father's Name (First, Middle	,						18. Mot	her's Nam	e (First, Middle	, Maiden	Surname)	
<u>"</u>	should be filled within 72 hours after death with the Maryland had Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	٩	Felix Albert So				19h Mailin	a Address	(Street			leanor At		ong or Town, State, Z	in Code)
2	id 2 slith an traul		Mary Somerville					•	•			eonardto			ip code _j
Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygiens. Infine 72 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	-		20b. P	lace of Disposemetery, cren					Date		ocation - City or	Town, State
2	Page ient o nt: F		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n State		les Mem				2007	nber 8,	Leon	ardtown,	Maryland
<u>=</u>	permit. Departm Importal any Inju		21. Signature of Funeral Service		,		22	. Name an				_			
α			Michael	Harde.	ne		9	P.O.	Box	y-Gar 270	diner Leonar	Funeral I dtown, M	Home, 0 2065	P.A. 50	
			23a. Par 1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused each lii	I the death ne.	n. Do not ente	er the mod	e of dyir	ng, such a	as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Ca	-d10	٠.د	arrh	yll-	الر						- wante
	/Medical Examiner		resulting in death)			a consequ	uence of):			,					
		Į.	Sequentially list conditions,		for as	a cunsilui	intition of):	141	inf	er CH	u			63	hai a-tes
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S . C	0-0	رسم	0~20	~	1000	eese					Yews
	icate be executed physician and sthe burial-transit	Exa	resulting in death) Last	U		a consequ	uence of):	-}							7
8760	ite be iysicia ne bur	dical		d											
Œ	9	Med	IF FEMALE:	1									-1		1.000
nerville, John Division or Vital Records, P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth	2 Feta	Ideath 3□	Ectopicp		у			5001	23d. Date of deli Month	very Day Year
_	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unk		t time of de	eath 5L	Other (sp	ecify) _			·			
۵	law requires that the de as been signed by the 2 should be detached	Ph	Part II. Other significant condit	ions contributing to	death b	ut not resu	alting in the ur	nderlying c	ause giv	en in Par	t I.	23e. Did	tobacco ı	use contribute to	the cause of death?
C 2	uires la sign ld be	d b	Stroke									1 🗆	Yes 2	□ No 3□ Pr	obably 4 nknown
	w red	lete	Micheles									24a. Was	an	24b. Were au	topsy findings available
John Becord	sician: The lavertificate has rector, page 2	ошр	Hypertension									auto perf 1∐ Yes	psy ormed? 2 1 No	death?	completion of cause of 2 No
1 7 1	ian: rtifica stor, p	Be C	25. Was case referred to medical	al						26. Pla	ce of Dea	th (Check only) I les	2 NO
S >	Physician: r this certificaral director, i		examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatie	ent 2	ER/Outpatien	t 3 🗆 DC	Oth	ner: 4□	Nursing H	ome 5□Res	idence	6 □Other (Spec	cify)
7	ding Phys	ü	27. Manner of eath 1 Natural 5 Pendi	28a. Date (Mo	e of Inju	ıry y Year)	28b. Time of Injury		8c. Injui Wor			28d. Describe	how inju	ry occurred	
_ in	Attending r death. sctor: After by the fune	catic	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation	()			M		Yes 2	□No	00/ 1	(0)	141 - 1	-
ر غ: رگ	or At uffer d Direct in by	rtifi	4 Homicide deter	mined 28e. Plac build	ding, et	ury - At no c. <i>(Specif</i>)	ome, farm, stro y)	eet, tactory	y, office			City or To	Street ar wn, State	nd Number of Hu e)	ıral Route Number,
omer Ville, Division or Vit	Hospital or Attend 24 hours after death. Funeral Director: /	S	29a. Certifier 1 Certify	ng Physician: To th	ne best	of my kno	wiedge, death	n occurred	at the ti	me. date	and place	and due to the	e cause(s	and manner as	stated.
50	H 22 H	Medical Certification: To		Examiner: On the and ma	basis o	f examina									
0/	To the within 2 To the complex	Me	29b. Signature and title of certifi	ər				290	c. Licens	se numbe	r		29d. Da	te signed (Monti	h, Day, Year)
	00/		ho-	250	TD	PLYS	16390		40	351	7		12	11107	
	12			who completed cau		leath (Item	23a) (Type.	Print)				_			
	3 4		2001	LIKE DU		2550	שונה ל	(outo	1 Rd	le	every	an, ma	Soi	(70	
	Sta Regista		31. Date filed (Month, Day, Year DEC 0 4	2007	registr	ar's Signa	The Age	948							

DHMH 17 Rev 1/2001

	FOI	partment of Health and Me	ntal Hygiene
u ex	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 2 1 3 8 5 7 Date of Death 3, Time of Death
Physician /Medical	Philip F. Schneider		Month Day Year ovember 10 2007 9:50 at M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
· · · · · · · · · · · · · · · · · · ·	Genesis Spa Creek Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Annapolis // If Under 1 Year If Under 24 Hrs. 8	Anne Arundel Date of Birth 9. Birthplace (State or Foreign
Funeral Director	178-16-3133 1 TX ^M 2□ F 86 Yrs.	Months Days Hours Min.	(Month, Day, Year) Country ar. 15 1921 Pennsylvania
pug	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or I	ocation	10d. Inside City Limits
Manyla f sho ied at	Maryland Anne Arundel Annapolis		1⊠Yes 2 No
vith the Mar or 28a-f si be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a cust by ust by	35 Milkshake Lane	21403	USA
r items 23a siner must Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Army	 Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric 	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.
urs aft al", or Exami	Marined 2 Marined 1 A Find A Find States 2 No A Fin	1 ☐ Yes 2 🔀 No Specify:	Specify: White
lygiene. her than "natura tt, the Medical E Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of working	16b. Kind of Business/Industry
within sne. than " than "	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Maryland State
filed v Hygie other the	17. Father's Name (<i>First, Middle, Last</i>)	ords Manager 18. Mother's Name (F	Records Department First, Middle, Maiden Surname)
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	August J. Schneider	Flora A.	Adams
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		ling Address <i>(Street and Number or Rural F</i> Fernham Ct. Crofton	Route Number, City or Town, State, Zip Code)
s 1 an of Heal item 2	20a. Method of Disposition 20b. Place of Dis	position (Name of Date ematory or other place)	20c. Location - City or Town, State
Page Iment Iant: If jury or	4 Donation 5 Other (Specify) Ressured	tion Cemetery 11/2	
permit Depart Import any in		22 Name and Address of Facility Cobert E. Evans Fune: 6000 Annapolis Rd. 1	
公	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each fine.		espiratory arrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Arryltonia.	Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):		
je je	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		
executed in and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last		
ate be executed hysician and the burial-transit	Due to (or as a consequence of):		
the	d		
attending properties as local for use as cian/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	. Die	23d. Date of delivery
requires that the death certificen signed by the attending pool to be detached for use as hould be detached for Use as ted by Physician/Mec	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
that the de detached detached	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
uires t signe Id be d	talue to torve.		1 Yes 2 No 3 Probably 4 Unknown
aw requires been signal should be			24a. Was an 24b. Were autopsy findings available
: The law requii cate has been s page 2 should			autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
Physician: The I this certificate ha ral director, page:	25. Was case referred to medical examiner?	26. Place of Death (
The life of the li	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		5 Residence 6 Other (Specify) d. Describe how injury occurred
th.: After e funera	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident Investigation		. Describe now injury occurred
ital or Attending F rs after death. ral Director: After led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office 28	Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier 127 ertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, an	
To the Hosp within 24 ho. To the Fune completely fil	(Check on one) edical Examiner: On the basis of examination and/or and manner stated.		
To the within To the compl	29b. Signature and little of certifier	29c. License number	29d. Date signed (Month, Day, Year)
WALK	30. Name and address (parson who completed colored fleath (Item 23a) (Type	Print) a	11/24/01
10 Par	600 Ridgely Are Si	ute 231 Au	na bolis - Aditya Chopra
State Registrar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	land.	
	The state of the s		

7: Chard conduct Stein
07-08889 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		State of Maryland / Department of Health State of Maryland / Department of Health State of Dealth State of Dealth State of Dealth State of Maryland / Department of Health State of H			. No. 200	7 39868
Physici		1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death
ledical Exam	iner	Richard C. Beern iii	y, Town, or Location of Death	November	16, 2007 4c. County of Death	1232 hrs
			napolis		Anne Arundel	
Funeral			nder 1 Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Bir Foreid	
Director		218-98-0172 1XM 2 F 25 Yrs.	nths Days Hours Min.		6 1982 Co	Waryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
A .:	L	Maryland Anno Arundol Annanolis				1 XYes 2 No
Aaryland 28a-f show 1.at once.	Director	10e. Street and Number 10f. 2	Zip Code	100	g. Citizen of What Cour	ntry?
the N 3a or 2		5 B Heritage Ct.	21401		USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygine Mental Hygine 23 ris market other than "natural", or items 23a or 28a-f sh. 27 is market other than "natural", or items 23a or 28a-f sh. 27 is market other than "natural", or items 23a or 28a-f sh.	neral	Amend Francis KV and a KV and a Market KV and	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	ican Indian, Black,
er dea	Fun	1 Yes 2 X No	2 X No specify:	,	Specify: B1	ack
urs aft tural'	d by	l or Dates:	ual Occupation (Give kind of v		16b. Kind of Business/	
6 72 ho nn "na cal Ex	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of v	working life. DO NOT use reti	red)		
5-0036 Hed within 72 Hygiene. To other than "	Comple	12th 0 Une	mployed		N/A	
215-(be filed v ntal Hygi rked oth	Be C		18.Mother's Name		aiden Surname)	
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med	lo B		Street and Number or F	Moore Rural Route Numb	er, City or Town, State	e, Zip Code)
MD d 2 sho lth and n 27 is numatis		Yvette Moore(Mother) 5 B Her	itage Ct.	Annapol	lis, Md.	21401
Dre, MD 212 es 1 and 2 should be of Health and Menta If item 27 is marke her traumatic even		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (N	lame of cemetery, ce)	Date	20c. Location - City or	Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		4 Donation 5 Other Specify: Memorial P		26-07	Annapoli	s, Md.
Balt Sermit Depart Impor			Regisse Figure Son			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	West St. An de of dying, such as cardiac o	napolis r respiratory arres	st, shock, or heart	401 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Gunshot Wounds				Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
	Examiner	Course Enter Underlying Course (Disease or injury that initiated				
ecuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of):				
	Physician/Medical	d. UNPENDED AMENDED				
760, cate be ex physiciar he burial	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	y
30x 6876(death certificate e attending phy for use as the b	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dear 4 Pregnant at time of death 5 Other (S)		ancy	Month (Day Year
Box e death of the atten	nysic	1 Yes 2 No 9 Unknown Unknown Unknown	pecify)			
P.O. B s that the d gned by the	by Pr		ing cause given in Part I.	F====	acco use contribute to	
S, P.(2 No 3 Pro	
ords, aw requir as been s	plet			24a. Was ar autops	y prior to	utopsy findings available completion of cause of
	Completed			perform 1 Y Yes 2		es 2 No
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 4 Inspitate 2 EB/Outsetient 2	26.Place of Death (Check			
n of V ding Phys After thi funeral di	. To	1 Yes 2 No	DOA Other A Nursin		tesidence 6 Othe	r: Scene
on on cending ath.	tion	1 Natural 5 Pending Nov 16, 2007 1223 hrs	1 Yes 2 ✔ No	Subject shot		
Division tal or Attendi rs after death. al Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ory, office building, etc.	28f. Location (St	reet and Number or Ru	ural Route Number, City
ie on	Certification:	4 Momicide determined (Specify) Single Family		1000 Madison	ate) Street, Annapolis, M	1D
To the Hos within 24 h To the Fun completely		23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at to come one) Wedical Examiner: On the basis of examination and/or investigation, in the basis of examination and/or investigation, in the basis of examination and/or investigation.				
To the within 2	Wedical	and manner stated.	29c. License number		29d. Date signed (Mo	
do		Mount my) inch in is	O.C.M.E.		November 17, 20	
1/1/2		30. Name and address of person who completed cause of death (Item 23a)			, -	
Cr.			n Street, Baltimore, M	D 21201		
	ate	11011 0 11 0007 640 64 64				
Regis						
DHMH 17 Rev 1/2	001	ORIĞİNAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 26, 2007 NOVEMBER 7:30 IRWIN SCHECKER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY 3330 NORTH LEISURE WORLD BLVD #816 SILVER SPRING Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months 1**√**M 2□F NEW YORK 03/24/1921 86 064-16-8621 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Tyes 2 No SILVER SPRING MARYLAND | MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 3330 NORTH LEISURE WORLD BLVD #816 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∏Yes 2 No Yes, Give 1 ☐ Never Married 2 → Married WHITE 1 ☐ Yes 2 ☐ No Specify. Specify: WWII 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) PRIVATE College (1-4or 5+) Elementary/Secondary (0-12) CORPORATION ACCOUNTANT 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY LAPIDUS HARRY SCHECKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Statem Code 1906 19a. Informant's Name/Relationship (Type. Print) 3330 NORTH LEISURE WORLD BLVD #816, SILVER SPRING, JULIA SCHECKER WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ADELPHI, MARYLAND LEBANON CEMETERY 11/28/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 20852 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death 23 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 YEARS ISCHEMIC HEART DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. X No 3 Probably 4 Unknown CHRONIC KIDNEY DISEASE 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

that the death certificate be executed burial-trai attending physician for use as the ned by the a Division or Vital Records. sign 1 be page 2 s has certificate director, this After t

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Director:

within 24 hours a To the Funeral D Hospital

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completely

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show notified at

ral", or items 23a or Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Ikem 27 Is marked other than "natural"; or iter any Injury or other traumatic event. The Martisel Exember.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

death with the Maryland

Examiner Physician/Medical þ Completed Be 2 Certification:

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D20674

29d. Date signed (Month, Day, Year)

NOVEMBER 26, 2007

30. Name and oddress of person who completed cause of death (Item 23a) (Tyr.e, Print)

DR. STEVEN HELLMAN, 6420 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852

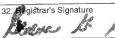
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 28 2007

6 Could not be determined





Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Satterfield 9:05 P ^M 2007 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 475 Dueling Way Berlin Worcester If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year Date of Birth (Month, Day, Year) 8/6/1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F Months Days Hours 219-03-0111 86 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 475 Dueling Way 21811 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examlner 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Ayres Dellie Collins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas C. Satterfield /husband 475 Dueling Way, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Evergreen Cemetery 11/30/2007| Berlin, MD eral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Fu 108 William St., Berlin, MD 21811 23a. Part L. Ener to dise vie, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 690 /Medical Due to (or as a consequence of): Examiner promay Anten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 2**5** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 T Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 900H0053714 11/28/07 Berun no 21811 / Lettry materni 30. Name and address of pers o completed cause of death (Item 23a) (Type, Print) fuck Fran 31. Date filed (Month, Day, State NOV 2 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 39871 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 25, 2007 Louise Brown Snowden November 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata Charles Genesis Elder Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 96 Director 11,1911 Maryland 216-24-8152 August Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow ury or other traumatic event, it a Mudical Examinar man be notified at TX Yes 2 No Directo Maryland Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 United States 1 Magnolia Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ৺ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black δ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janitoria1 7th Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Alston Brown ၉ Albert Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Solomons Rd. Annapolis, MD 21401 William Brown-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Brinsfield-Echols November 28, 2007 Charlotte Hall, MD 22. Name and Address of Facility Archart-Echols Funeral Home, 211 St. Mary's Ave Box 567 La Plata, MD 20646 21. Signature of Funeral Service Licensee M01458 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DUL MULAN CAROLG /Medical Due to (or as a consequence of): Examiner RENAL CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed CARDIO UASCULAR Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificete has b irector, pege 2 sl 1 Yes 2 No After this certification funeral director. Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 2 ☐ EB/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Iniun 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier MS CMD D0006018 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)
RICHAM TKELY 19064 FEM DOCK RL KING GEORGE , VA 22485 RICHARD TKEIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 28 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 6:30 A.M NOV. 23, 2007 Sanh Thi Tran /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XF July 28, Director 216-08-9151 98 1909 Vietnam Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 XNo notified Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene. ms 23a 105 Timberbrook Lane #302 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Completed by Specify. 3 X Widowed 4 Divorced Asian 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chanh Tran ည Mau Thi Tang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 Timberbrook Lane #302
Gaithersburg, MD 20878 19a. Informant's Name/Relationship (Type. Print) Item 27 is other tra Hong Nguyen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date DEC. permit. Pages
Department of I
Important: If It
any Injury or o 1 ☐ Burial 2 X Cremation 3 X Removal from State Fairfax Memorial F.H. 2007 Fairfax, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Fairfax Memorial Funeral Home 21. Signature of Funeral Service Licensee -migan M01508 9902 Braddock Road, Fairfax, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROTIC CARDIOVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intime liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for an aimprovement offs The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown URINARY INFECTION TRACT 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an DEM ENTIA certificate has be rector, page 2 s autopsy HYPERNAT REMIA 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division or Vital Records, To the Hospital or Attending Physiclan: within 24 hours a

To the Funeral E

completely filled is

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 35941 M.D

DR.

401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOVEMBER 23

MD 20852

ROCKVILLE

State Registrar

Medical

MAMUR 31. Date filed (Month, Day, NOV 28 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00 PM Mary Helen Vallandingham 2, 2007 December /Medical 4a. Facility Name (If not institution, give street and number)
St. Mary's Nursing Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year) July 25, 1918 if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 1 F 89 Maryland 212-56-0402 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 'natural'', or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Marvland St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26040 Bryan Court 20659 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎦 No Specify: 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Frank Thomas Elizabeth R. Thompson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26040 Bryan Court Marjorie J. Hicks / Daughter Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December 6, 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Cemetery Bushwood, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec Examiner burial-transi Due to (or as Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe rmed? 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 | ER/Outpatient 3∏ DOA မ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 🔊 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed

DEC 04

24035 Three Notch Road 31. Date filed (Month, Day, Year)

James P. Jarboe, M.D.

cause of death (Item 23a) (Type, Print)

Hollywood, MD 20636

Examine physician and s the burial-translt Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital after death.

I Director: After din by the fur To the Hospital of within 24 hours aft To the Funeral Dicompletely filled in

Funeral

Director

in then "natural", or iteme 23a or 28a-f show the Medical Exeminer must be notified at

permit. Pages 1 and 2 should be fited within 72 hours after death v Department of Health and Mental, Hygiene important: If Item 27 is marked other then "natural", or Iteme 23a any injury or other traumatic event, the Mudical Examines manner manner.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

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29a. Certifier

(Check only

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НМН	17 Rev	1/20	н

29b. Signature and title of certifier

D01850

1 Cartifying Physician: Tuthe best of my knowledge, death occurred at the time, date and place, and due to the raise(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who comof death (Item 23a) (Type, Print) 4203

EVEENSBURY Rd HYattsville MD 2018

31. Date filed (Month, Day, Year)
NOV 2 8

		,	For State Registrar	State of Mai	ryland	l / Depa <i>Cel</i>	artment of rtificate of	Health ar Death	nd Mer	ntal Hy	giene Reg. No.	_ ~ ~	7	398	75
П	3.		Decedent's Name (First, Middle, Las	t)					2.	Date of De	eath		,	3. Time of D	eath
	Physicia /Medic		Beulah L. Wrigh	nt					N	Month OVem	_{Day} ber	20	^{rear} 2007	124	2 M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of I	Death		4c.	County of	Death		
			Anne Arundel Me	edical Ce	nter	<u>-</u>	Annar	polis			A	nne	Aru	nde1	
	Funeral		5. Social Security Number 6. Se	7. Age		st birthday)	If Under 1 Yea Months Days		Hrs. 8. Min.	Date of Bir (Month, Da	rth ay, Year)		Count	ace (State or i	-oreigr
	Director		214-18-3997 Usual Residence of Decedent		83	3 Yrs.			D	Date of Bir (Month, Da ec 1	192	3 1	1ary	land	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10	d. Inside City	Limits
	Mary -f sh	to	Maryland Anne Ar	undel	Ar	napo	lis							1 Tyres 2	. □ No
	r 28a	Directo	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of Wh	at Count	ry?	
	h witl	al D	505 Oaklawn Ave	9			214	101				USA			
	deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S	13.	Was Decedent of If Yes, specify Cu		n? (Specify	y Yes or No	o-	14. Race -	America White, e		
5-0036	be filed within 72 hours after death with the Maryland tral Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 □ X Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:)		1 □ Yes 2 X □ No		401101110	un, 010.)		Specify:			
ָ ה	72 hc natu dical	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece	dent's Usual Occi kind of work done DO NOT use retir	upation e <i>during most</i> o	of working		16b. Kii	nd of Busi	nes <i>s</i> /Ind	ustry	
2	filed within 72 h I Hygiene. other than "nati ent, the M dira	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+)						Dani	4 -			
7	iled v Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)	0		D	omestic	18. Mother's	s Name (F	irst Middle				mily_	
yland	ild be f fental f rked of tic ever	Be (Unobtainable					Clar			, maidon	ourname,			
2	houk id Me mark matik	잍	19a. Informant's Name/Relationship (7	vne Print)		19b Mailii	ng Address (Stree				ner City o	rTown S	tate Zin i	Code)	
<u>B</u>	nd 2 s Ith ar 27 is rtrau		Charles Graves				Bouche			napo				,	
ē,	es 1 and 2 should be of Health and Mental I Item 27 is marked o r other traumatic eve		20a. Method of Disposition		20b. Pk		pation (Name of hater/2050ther pi		Date	7+		cation - C			
galtimore,	Pages nent of H ant: If Ite ury or of		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specify</i>				1 Garde		1-26	-07	Ann	apo1	lis,	Md.	
<u>=</u>	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	see		W	MName Rocked	pes of acil	ons :	Mort	uary	, P.	Α.		
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	blications that caused to one cause on each line	he death.	. Do not en	er the mode of dy	ying, such as ca	ardiac or re	espiratory a	arrest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a. Cienus	10	UASCI	ruran	DISI	nsr					Onset and De	
	/Medical Examiner		resulting in death)	Due to (or as a											
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		11 LIZ	CVI	4						_	
	ted nsit	nine	Cause. Enter Underlying Cause (Disease or injury	Duc to (or as a	consequ	crice oi).									
,	execuna and all-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	ence of):									
8/60,	icate be executed physician and s the burial-transit	dical	· ·	d											
9	rtificat ng phy as th	/ledi	IE EEMALE.												
X Q Q	death certiff e attending d for use as	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pr 1 Live birth 2			∃Ectopic pregnan	су			2	23d. Date Mont		•	
5	the dea y the at ached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 22 No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of de	ath 5	Other (specify)					WOITE		Day Ye	ai
J.	w requires that the death certif been signed by the attending should be detached for use as		Part II. Other significant conditions of	ontributing to death but	not resul	tina in the u	nderlying cause o	iven in Part I		23e. Did	tobacco u	se contrib	ute to the	e cause of dea	ath?
ďs,	requires that een signed b nould be deta	d by	•	-			,g a					-		ably 4 ∐Un	
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VITAI	sician: The law certificate has t irector, page 2 s	ပိ	25. Was case referred to medical					26. Place o	of Death (C	1□ Yes	21 No	1 L	Yes	2∐ No	
	Physician: this certificanal director,	O B	examiner? 1 □ Yes 2 ☑ No	Hospital:	t 2 🗆 E	R/Outpatier	ıt 3□ DOA O	thor:		Res		5 ∏Other	(Snecify	•)	
יסר	ding Phys J. After this funeral di	Ë	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time o	f 28c. Inj			. Describe				<u>/</u>	
	endir ath. or: Af he fui	atio	1 Natural 5 Pending 2 Accident investigation			,,		☐Yes 2☐No	0						
JIVISION	or Atta	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	y - At hor (Specify)	ne, farm, sti)	reet, factory, office	e	28f.		Street and wn, State		or Rural	Route Numb	∋ <i>r</i> ,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	(Check only 2 Medical Exam	ysician: To the best of liner: On the basis of e	examinati	/ledge, deat	h occurred at the	time, date and opinion, death	place, and	d due to the	cause(s)	and man	ner as sta	ated. the cause(s)	
	ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner state	ea.		29c. Licer	nse number	-		29d. Dat	e signed	(Month. I	Day, Year)	
	H & H)_	AL NI	Allena ch				8118	-		Nou	_		07	
	THE		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Tvne	Print)	3/1 3			, , , ,	<u> </u>			
	,		STANLEY MAT	141NS	30	0 131	Print)	210	MU	NAC	ULLS	m	2 4	1491	
	Sta		31. Date filed (Month, Day, Year) NOV 2 7 20	32 egistrar	's Signati	ure	000								
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			1 10000	State of Maryland							
			1 - For State Registrar	Otate of Maryland		tificate of			Reg. No.	41111	39876
			1. Decedent's Name (First, Middle, Last,)				2. Date of De	-		3. Time of Death
	Physici /Medio		Kelvin L. Wrig					Novemb	oer	20 200	$07 \ 4:22 \ A^{M}$
17.14	Examin	er	4a. Facility Name (If not institution, give		1 0 -	4b. City, Town, o				County of Dea	
	Funeral		Baltimore Washing 5. Social Security Number 6. Sec			If Under 1 Year		Hrs. 8. Date of Bir			Arundel thplace (State or Foreign ountry)
	Director		246-90-2076	XM 2□ F	2 Yrs.	Months Days	Hours N	Jan 9			
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho lied a	tor	Maryland Anne Ai		evern						1 □ Yes 2 XNo
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	ountry?
	23a c		7956 Innkeeper	Dr.		2114				SA	
	itams	by Funerai		12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.))-	14. Race - Ame Black, Whit	
980	urs afi ai', or	by F	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 3/ ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2M No	Specify:			Specify: B1	.ack
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	lcation le completed)	16a. Deced	ent's Usual Occu kind of work done OO NOT use retire	pation during most of	workina		nd of Business	·
12	within ene. then '	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)		00 <i>NOT</i> use <i>retire</i> 1emist	nd)	_		timore lic Sc	county
0 7	filed Hygie other ent,	င္ပိ	12th 17. Father's Name (First, Middle, Last)	6yrs		10111100	18. Mother's	Name (First, Middle	1		.11001
<u>la</u>	dental dental rked tic ev	To Be	Fred Wright Sr	•			Netti	e Mae Ba	rfi	e1d	
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street	and Number o	r Rural Route Numb	er, City o	r Town, State,	Zip Code)
	1 and dealth sm 27 ther tr		Tanya Wright(W: 20a. Method of Disposition		7956	Innke	eper D	r. Seve		Md . 2	
nor	ages int of l t: if it		1 Donation 5 Other (Specify)	nemovariiom State		sition (Name of natory or other pla .ven Cer		-27-07		,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens					ons Mort			
<u>m</u>	Depa Impo any ir	b i	Jarry B. Re	ese 1100483				Annapoli			
L			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not ente	er the mode of dyi	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ence of):						
	and -trans	Examiner	Cause (Disease of injury	c Due to (or as a consequ	anno off:						
760,	The law requires that the death certificate be executed at the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	ā			ierice or).						
89	ifficate g phys	edic		3							
Box	th cert lendin r use	an/M	230. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	v			23d. Date of de	-,
О. П	ie dea the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify) _	,			Month	Day Year
۵.	that the ed by detac	by Physician/Med	Part II. Other significant conditions cor	ntributing to death but not resu	ilting in the un	derlying cause gr	ven in Part I.	23e. Did t	obacco u	se contribute to	o the cause of death?
Records,	quires n sign		D	iabetu trp	I			11	Yes 2	ZNo 3□P	robably 4 🗆 Unknown
000	ne law requir has been s ge 2 should	piet		ypertenew.				24a. Was			utopsy findings available completion of cause of
	Physicien: The la r this certificate has ral director, page 2	Completed	H	ypulitidem	_			perfo	ormed?	death?	s 2□ No
Viita	icien: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		04		Death (Check only			
ō	Attending Physicien: r death. ector: After this certifice by the funeral director.	.: To	1 Yes 2 No	1 Linpatient 2001	ER/Outpatient 28b. Time of	28c. Inju	ry at	ng Home 5 Resi			ecify)
lon	ath. r: Afte	ation	1-Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1	rk?]Yes 2∐No				
Division of		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Płace of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (City or To			ural Route Number,
	Hospitel of the hours all Euneral D Funeral D tely filled in		29a. Certifier 12 Certifying Phys	sician: To the best of my know	uladga daath	accurred at the ti	me date and a	loop, and due to the		and manner o	o state d
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edicai									
	To the within 2 To the complet	×	29b. Signature and title of certifier	ME	\	29c. Licens	se number		29d. Dat	e signed (Mont	th, Day, Year)
	Dell	J	· cax	V - 17)	D3	8158		11	121/0)Z
	B		29b. Signalure and title of certifier 30. Name and address of person who co LKG A D; MARZZI 31. Date filed (Month, Day, Year) NOV 2 7 2007	impleted cause of death (Item	23a) (Type, I	Print)	um C.	it in	And	epol15	MD 2 140,
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signar	yre de	7 0 = 1 0 C	130	7W 700		, ,	
	Registr	ar	NUV 2 7 2007	person D	GOS	W.					

DHMH 17 Rev 1/2001

Wright, Kelvia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 23, 2007 Bruce Raymond November 11:25 P™ Witte 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House 6. Sex 1 X M 2 ☐ F | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 23, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign New Jersev 573-70-2865 60 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County 10d. Inside City Limits 1 ☐ Yes 2 XNo Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13239 Lake Geneva Way 20874 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1965–67 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🕅 No Specify ^{Specify:}White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Mechanic Machine Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Witte Henrietta (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Witte/wife 13239 Lake Geneva Way Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Chesapeake Crematory 11/28/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Squamous Cell Carcinoma of Tonsil disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, any adding to find distance. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 ▼ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show

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item 27

permit. Pages 1
Department of H
Important: If iter
any injury or ott

3altimore, Maryland 21215-0036

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Examiner ohysician and the burial-transi Physician/Medical ä tending signed by the ģ Completed has Be this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera Certification:

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2X No

5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

1 X Natural

29a. Certifier

2 Accident

29c. License number D64615

29d. Date signed (Month, Day, Year) November 24, 2007

10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 Genevieve Wroblewski, 31. Date filed (Month, Day,

State Registrar

Medical

32. Registrar's Signature Year)



			1 - For State Registrar	State of N	Marylar	nd / Depa <i>Ce</i>	artmeı <i>rtifica</i>	nt of H te of L	ealth a Death	and M		giene Reg. No	2007	7 39878
40	Physic /Medi		1. Decedent's Name (First, Middle, La Charline Miles	Wallace		·				N	2. Date of Dea	ath	6, 20°07	3. Time of Death 10:50 P M
	Examir		4a. Facility Name (If not institution, given 3160 Gracefield 1	of institution, give street and number) efield Road #2228 4b. City, Town, or Location of Death Silver Spring								4c. County of Death Prince George's		
	Funeral Director		493-22-9808	Sex 7. 1 □ M 2 □ X F		. last birthday) 86 Yrs.	If Unde Months	er 1 Year Days	If Under: Hours		8. Date of Birt (Month, Da 1ay 10	y, Year	9. Birt 21 Miss	thplace (State or Foreign puntry) SOUT i
	e Maryland 3a-f show tified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge	eorge's		ity, Town or Lo								10d. Inside City Limits 1 □ Yes 2 ▼No
	th with th 23a or 24 ist be no	Funeral Director	3160 Gracefield 1	Road #222	8		10f. Zi 209	ip Code 04				10g. Cit	tizen of What Co	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show with Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2[If Yes, Give Year or Date:	s? XNo		Was Dece If Yes, spe 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, White Specify: White	e, etc.
21215-0036	within 72 ho lene. than "natur the Medkal I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4c	or 5+)	16a. Dece (Give life. Homema	kind of w DO NOT i	ual Occupa ork done d use retired	ation luring mosi)	t of workin			ind of Business/	Industry
Maryland 2	ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last Nelson Appleton I	,					18. Mothe Eva M		(First, Middle,	Maider	n Surname)	
	and 2 sho alth and 27 Is ma		19a. Informant's Name/Relationship William P. Walla			- 1							or Town, State, 2	
Baltimore,	Pages 1 ament of He ant; If Item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from Sta	te Ch	Place of Dispo cemetery, cre esapeal	osition (Na matory or Ke Cr	ame of other plac emate	e) ory	11/29	ate 9/07		ocation - City or tsville,	
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Lice	altte	МО	1251 B	ever1	v I	Heck	rotte	P.A.	C1:	P.O. Bo	le. MD 21029
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8760,		dical		d										
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al Reco	The law ate has b page 2 sl	Completed			-	-		-					prior to death?	utopsy findings available completion of cause of 2 No
or Vital	ys dir	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpa	atient 2	ER/Outpatier	nt 3 □ D	OA Othe			<i>(Check only o</i> ne 5□Resid		6 X ☐Other (Spe	assisted cify) living
ion o	fter The		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	njury Day Year)	28b. Time o Injury	f M	28c. Injury Work 1 ☐ `	rat ? ⁄es 2 □ I		8d. Describe h	now inju	ry occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building,	etc. (Speci	fy)					City or Tou	vn, State	9)	ural Route Number,
	ne Hosp n 24 hou ne Fune bletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example Medical Example Pl 2 Medical Example Pl 2 Medical Example Pl 3 Medical Example Pl 4 Medical Example Pl 5 Medical Example Pl 6 Medical Example Pl 7 Medi	nysician: To the be miner: On the basis acd manner	of examina	owledge, deat ation and/or in	h occurred vestigatio	d at the tim n, in my o	ne, date an pinion, dea	id place, a ith occurre	nd due to the ed at the time,	cause(s date an) and manner as d place, and due	s stated. e to the cause(s)
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(10	2)02		30. Name and address of person who E.S. Machado, M.I					.1ver	Spri	ng, N	ر ال 2090	4		
Ĭ	Sta Registr		31. Date filed (Month, Day, Year)	32. R	strar's Sign	ature	hast							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JR 26 200 1 CLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours 1 XM 2 ☐ F 59 Director 220-52-4406 Feb 15, 1948 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ò 23a 6826 Carlinda Avenue 21046 United States Funeral , or Items Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. Minister Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William P. Wyatt Sr. Bettie J. Hoffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda W. Wyatt/Wife 6826 Carlinda Avenue Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svs. 11-28-2007 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 (old 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** la /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed 1eTusta burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate 250 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes patient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After ↑ Accident 5 ☐ Pending investigation Injury the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 and manner stated. 29c. License number 29b. Signature 2007

(1) ac

State Registrar 31. Date filed (Month, Day,

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NOV 29

32. Registrar's Signature

Physician /Medical **Examiner Funeral Director** death with the Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Funeral permit. Pages 1 and 2 should be filed within 72 hours after c Department of health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical once. ò Completed Be 2 **Physician** /Medical Examiner Examiner burial-trar and Division or Vital Records, P.O. Box 68760,

Physician: The law requires that the death certificate be executed attending physician for use as the buria this or Attending

2. Date of Death 1. Decedent's Name (First, Middle, Last) Novth 25,2007 Marilyn Weiler 10:32 P M 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genisis Waldorf Center Charles Waldorf If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 115-18-9111 80 January 26,1927 New York Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2√ No Prince Georges Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12503 Minnehan 20735 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ TNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teller Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Veit Helen Veit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12503 Minnehan Court, Clinton, MD Mark Weiler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State St. John Cemetery 11/29/07 4 □ Donation 5 □ Other (Specify) Middle Village, NY 21. Signature Funeral Service Licensee M00945 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. Tha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatu lung Cancer (Small Cell Month 5 Due to (or as a consequence of): Smaker Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTN 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? ⁄es 2∭No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R. Sindlevai D0061614 november 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. SINDHWANI PEMBROOKE SQUARE 11350 , WALDORF, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ORIGINAL

			For State Registrar	State of M	arylan		partment of F ertificate of		lental Hy	giene	2007	39881
	E 500	-3	Decedent's Name (First, Middle, L.)	ast)			ortinoato or		2. Date of Do	eath		3. Time of Death
	Physici /Medio		Chlomo C Vanist NOVENDEL.								, 2007	11:00 PMM
	Examir	ner	4a. Facility Name (If not institution, g Suburban Hosp				4b. City, Town, o Bethes	r Location of Death			County of Death ontgome1	CV
	Funeral	(8)	-	Sex 7. Ag		last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			place (State or Foreign
	Director		549-72-3842	1 X M 2□F		76 Yrs	Months Days	Hours Min.	Sept.	11, 1	931 Pol	Land
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or	Location				1	10d. Inside City Limits
	a-fsh ified	ctor	Maryland Montgo	mery	Ro	ockvi	11e					1X Yes 2 □ No
	h with the Maryland 23a or 28a-f show st be notified at	Funeral Director	10e. Street and Number 18 Cedarwood Cou	rt			10f. Zip Code 20	854		10g. Citiz	U. S. A	
etan 300 1215-0036	within 72 hours after death wene. than "natural", or items 23a the Medical Examlner must I	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: V	
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tefan 2300 21215-0	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 8	5+)		e. DO NOT use retired ysicist	a()		υ.	S. A.	
24 2	offied Il Hygi Other /ent, t	BeC	17. Father's Name (First, Middle, Las	-			,	18. Mother's Nam		e, Maiden S	Surname)	
tomo 107 at Marylan	Duld be Ments arked atic ev	TO E	Ignac Janowsky					Cesia	(Unas	certa	inable)	
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SIE	Pages nent of nt: If i		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				of Remembr		7/2007	C1a	rksburg,	, Maryland
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4	s that ned by	by Ph	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the	e underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
ords	equire en sig ould b	ed b		·					1 🗆	Yes 2□	No 3□ Prob	oably 4 Dunknown
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ō	Phy this ral di	<u>2</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	iry	28b. Time	e of 28c. Injur	4 Li Narsing Tie	me 5 ☐ Res 28d. Describe		Other (Special	(y)
ion	Attending Fr death. sctor: After by the funeral	atio	1 Natural 5 Pending 2 Accident investigation		y Year)	Injur		Yes 2 □ No				
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	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying F	thysician: To the best miner: On the basis o and manner st	f examina	owledge, de ation and/or	eath occurred at the til r investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause(s) , date and	and manner as s place, and due to	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of pertifier	00/			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	18		• WWW					D62949		Nove	mber 26,	, 2007
	10		30. Name and address of person who Dr. Natasha P.	Haag 8600	01d		getown Roa	d, Bethes	da, Ma	rylan	d 20814	
R.	Sta Registr		31. Date filed (Month, Day, Year) NOV 28 2	32 egistr	ar's Signa	ature	forte					

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State of Maryland / Department of Health and Mental Hygien [2]

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			1 - State Registrar		Ce	ertificate of	Death	Reg	g. No.	0 0 0 0 1
	Physic /Medi		1. Decedent's Name (First, Middle, Las Dolores	Ruth Ask	ew	•		2. Date of Death December	92 20°07	3. Time of Death 8:35 a M
	Exami		4a. Facility Name (If not institution, given Oak Crest	e street and number)		4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore				
	Funeral Director		E1E 10 3100		(In yrs. last birthda 93 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day March 2	7, 1914 9. Birth	alace (State or Foreign
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or i	Location			1	Od. Inside City Limits
	he Mary 28e-f sh	Director	Md. Baltimo	re	Baltimor					1 □Yes 2X No
	ath with ti	ral Dir	10e. Street and Number 8820 Walther	Blvd.		10f. Zip Code	21234	10	10g. Citizen of What Country? USA	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be required at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 [] Yes 2 [X] No II Yes, Give Year or Dates:		I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: W	
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	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (7 Barbara Christ/ N	• • • • • • • • • • • • • • • • • • • •		ling Address <i>(Street i</i> 52 Glen K i			City or Town, State, Zip , Md. 2120	
altimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specify			position (Name of ematory or other plac Valley Mem		Date 20	Timonium,	
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DIVISION	lo tha Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	treet, lactory, office		28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
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	Vith To 1	Σ	29b. Signature and title of certifier	7/)	29c. License		29d	. Date signed (Month, I	Day, Year)
	1		30 Name and address of	omplated assist	th (the = 22 -) ==	06	1785	1	2/12/0	/
	5		30. Name and address of person who c	nn 8800	Walth	er Blud	Partvill	e MP Z	1234	
	Sta Registr		31. Date filed (Month, Day, Year)	36. Registrar's	Signature	antis		/		

8:35 AM

Dolores Askew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Charles Bachman DECEMBER 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREN BURNIE FALTIMORENIACHEMICITON MEDICAL CENTRE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreig Country) **Funeral** 1 X M 2 □ F 212-52-9631 Director 08/16/1946 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int! If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1814 Norfolk Road 21061 United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 **X** No If Y*e*s, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Tailor Clerical Apparel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Lewis Bachman Evelina Hobson ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Norfolk Road, Glen Burnie, Maryland 21061 Carol Ann Bachman (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of It Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 12/12/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. Market. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease shock, or heart failure. emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 687605 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ™nknown 1 🗌 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **N**o 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MI December 9 2007 Name and address of persor ho completed cause of death (Item 23a) (Type, Print) Glen Prime MD O, beental 501 ONNE

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32. Registiar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 39884 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 8:25 p ^M December Warren Harding Brooks, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 29 1944 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 213-44-8223 63 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD Cecil Perryville Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 300 Carter Court, Apt. B 21903 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Engineering Maryland F Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harding **Brooks** Hallie Anderson Warren Ennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Firstneck Road, Johnsonville, SC 29555 Melissa D. Lopez - daughter Baltimore, Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/11/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee H. Williams Cremation Society of Maryland, 299 Frederick Road, Baltimore, Fu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ONSILLAR CARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to inchediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical Box (23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my asiais. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification

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RODKS, WARREN

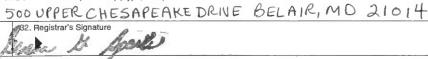
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Reg

J. KEVIN LYNCH, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D35012

DECEMBER 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:50 P M John Herman Bosse December 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F Director 92 212-01-5577 April 4,1915 Utah Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, Rm 415S 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 TayYes 2 □ No If Yes, Give Year or Dates: 1942 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify ģ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Export Manager Rustoleum Paint es 1 and 2 should be filed w of Health and Mental Hygier f Item 27 Is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John George Bosse Gertrude Caroline Lenzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2024 Old Frederick Road; Catonsville, MD 21228 Mary Jane Fuhrman Sister permit. Pages 1 a Department of Hee Important: If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Injury or 1 ☐ Burial 2 ICC Cremation 3 ☐ Removal from State Metro Crematory 12/14/2007 Catonsville, Maryland 4 Donation 5 Dther (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of lines Service NO1290 le, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death neumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, any solid in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine be executed and Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 ☐ Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 은 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After 5 Pending investigation 1. Natural within 24 hours after community the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier Decenter 12,200

64

State Registrar

DHMH 17 Rev 1/2001

state 31. Date filed (Month, Day, Year)

DEC 1 3 2007

9203

32 Registrar's Signature

Maiden

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature Apollo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #10f Per FH G874 12/C3/OTcall of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BARNES 2007 11CHELLE December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA THE JOHNSHOPKING HOSPITAL BALTIMURE CITY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, DEC, / 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212-78-3469 1 □ M 2 🔀 F **Director** LAND Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA, 14. Race - American Indian, Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the ENDENWAL OCIAL h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be UVENIA VILLIAM EDWARD ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHASE MO 212 RRICK SALTIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) (NEPHE . Method of Disposition 20c. Location - City or Town, State Date 3 Removal from State rrial 2 □ Cremation 12-15-07 4 Donayon 5 Dother (Specify) KING MEM. WOODLAWN, 22. Name and Address of Funeral Service Licensee JR. FUNERAL HOME 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. In rediate Calise (Final frease or condition as ultimg in death) a. Provides the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which is the condition of the condition as ultimg in death). TO, MD 2121 Pespiratory Muscle Fatigue Due to (or as a consequence o): 30045 **Physician** /Medical Neuronyelitis optica Examiner 6 HONTHS Sequentially list conditions Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 phospholipid Sht pray 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, Division or Vital Records, P.O. re Hospital or At.
rours after death.
ru Director: Af within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

DHMH 17 Rev 1/2001

To the

6 ☐ Could not be

determined

ar Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifier

Medical

State Registrar

4 ☐ Homicide

29b. Signature and title of certifier

OTYCLE BYOWN

1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE MARYLAND 21207

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

GOUNDRITH WOLFESTREET

32. Registrar's Signature

07-09606 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Timothy Michael Baker, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0738 hrs December 11, 2007 Timothy **Medical Examiner** Michael Baker Sr. 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 3 Oakwood Road Apt. B Dundalk 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Days Min Months Hours 216-74-5815 Director Country) Maryland 44 Aparil 19, 1963 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c, City, Town or Location 1 Yes 2 XNo Maryland Baltimore Sparrows Point death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 9310 Sea Bay Court 21219 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 X Married or iten 2 X No Yes Specify: White f Yes, Give Year Yes 2 X No specify: Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) permit. Pages I and 2 should be fifled within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatic event, the Mediral F. Elementary/Secondary (0-12) College (1-4 or 5+) 5-0036 Concrete Worker Masonary 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Michael Baker Betty Jean Deckelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 9310 Sea Bay Court, Sparrows Point, MD. 21219 wife Michelle L. Baker 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery December crematory or other place) 1 Burial 2 XCremation 3 Removal from State Baltimore City, MD. Bayview Crematory 13, 2007 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee ²Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Anthony Colt Connelly per dvr 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failure. List only one cause on each line Medical Death a. Methadone and alprazolam intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED **21 per th g8/4 12-1/-0/ vt** #23a,27,28a-f, perME,g875, 1/8/08 TT X UNPENDED physician the burial -68760 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o <u>5</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 No 1 🗸 To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Division Natural Yes 2 y No Director: d in by the f Pending Fnd 12.11.2007 Fnd 7:34 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined 3 Oakwood Rd. Apt B Dundalk, MD Funeral (Specify) found residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number mī December 11, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) . Registrar's Signature Registrar DEC 1 2007

ÓRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Recomber BROOKS ALLINE 220 + /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center Arundel Anne If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 K F 92 213-18-6634 03/09/1915 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show , or items 23a or 28a-f shov aminer must be notified at 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 U.S.A. 1110 Crain Highway, N.W. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23; any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Brooks Milton Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Crain Highway, Glen Burnie, MD 21061 Royce Brooks (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/2007 | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1 2nd. Ave.S.W., Glen Burnie, MD 21. Signature of Funeral Service Licensee 21061 M00303 Singleton Funeral & Cremation Services 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical attending physic I for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4XJUnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed? res 20 No 3 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day 27. Marther of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 D/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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3 2007

DHMH 17 Rev 1/2001

32 Registrar's Signature

			For State Registrar	State o	f Marylan	-	artment of I rtificate of		Mental Hy	giene Reg. No.	007	39889	
*	Physici	an	Decedent's Name (First, Mide		_				2. Date of De Month	Day	Year	3. Time of Death	
	/Medi	cal	Pau1 4a. Facility Name (If not institution)	M give street and nur		urke	4h City Town	or Location of De			0,2007	5:49PM M	~
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1887	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)			rs. 8. Date of Bir	th	Q Riet	nplace (State or Foreign untry)	-
115	Director		578-12-5724 Usual Residence of Decedent	1√XM 2□F	87	Yrs.			n. (Month, Da Jan.	28,19	20 Was	shington, DC	,
	yland		10a. State 10b. Count	ry	10c. Cit	ty, Town or L	ocation					10d. Inside City Limits	-
	ith the Marylan or 28a-f show is notilitied at	ctor	Maryland Princ	e George	Во	owie						1 ☐ Yes 2 ☐ No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?	
	eath v	erai	12407 K	embridge D	rive adent Ever in U	2 12	Was Decedent of I		(Cassily Vos or No		ted Sta		_
21215-0036	be filed within 72 hours after death with the Maryland stel Hygiene. Ind chtar than "natural", or Items 23a or 28a-f show event, the Mudical Examinar must be notified at	by	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Fo	rces? ^{2 No} WWI	T T	Was Decedent of HI Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pu	erto Rican, etc.)		Black, White		
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lan	should be filed with Model of Model Mygiene marked other the Imatic event, The Model of Model	To Be	William C.	Burke					McDonald				
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relation				ng Address (Street					ip Code)	
	if Health Item 27 other tr		E. Marie Burke	(Daughter			3 Stonega						_
סר	0 0		20a. Method of Disposition 1XXBurial 2 ☐ Cremation				osition (Name of matory or other pla		18-2007		ation - City or		
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Ba	permit. Departmit. Importa eny inju	b l	+24/1	1 1111	MARO	11-3	2. Name and Addre		e funera Road, C1			6633 OLd 20735	
₩	₩ 550		23a. Part Enter he disease of shock, or heart failurg. Lis	or complications that to st only one cause on e	aused the deat	h. Do not en					1, 110	Approximate Interval Between	-
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	res tha	þ	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	inderlying cause giv	ren in Part I.			/	the cause of death?	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dec 9, 2007 **Physician** 8:00 AM Grafton Boswell Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10110 Dangerfield Road Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 29, 1922 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 → M 2 □ F 57726 7559 85 Washington DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2□No Director Maryland | Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10110 Dangerfield Road 20735 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. <u>ک</u> Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Operations Engineer Heavy Equipment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Boswell Annie Simmons ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna L. Boswell (Wife) 10110 Dangerfield Road, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Resurrection Cemetery 12-17-2007 Clinton, MD 22. Name and Address of Facilit Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee M00257 Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cell Lung **Physician** Small disease or condition resulting in death) ROS /Medical Due to (or as a consequence of): Examiner CPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending | for use as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Xo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 X Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director: A completely filled in by the fi 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the } 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 8926 Woodyard Rd. Suite 201 Clinton, MD MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Russel Brannan December Ĩ2, 2007 12:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Yea 5/18/1926 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 216-20-1806 81 Ohio **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 South Wind Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√2 Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Business Executive permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Brannan Marjorie Case 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 South Wind Road Towson, Maryland Pauline C. Brannan∕ Wife 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 12/17/2007 Pikesville, Maryland 22 Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 21. Signature of Funeral Service License as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER- metrostatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy VOVAAK 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

P.O. Records, or Vital

December 12, 2007

Maryland 21215-0036

Baltimore,

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To the Funeral Director; After completely filled in by the funer

hours after

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signed by the attending physician and

the Hospital or Attending Physician: Division

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Registrar

Medical

29b. Signature and title of pertifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1)ecember 12,2007 6701 N. Charles St. Balto. Md 2, 204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

DEC 1 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician William B. Chew, IV DECEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town, or Location of Death Examiner BALTIMORE HUSPITAL AGNES BATIMORE
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 / 1 4 / 1 9 1 8 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 89 705-05-7831 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 711 Maiden Choice Ln. PV619 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White ò 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 Chief Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William B. Chew, III Eleanor Rae Schmidt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly A. Chew/ Daughter | 11 N. Morerick Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State Crestlawn Mem. Gds. 12/11/2007 | Marriottsville, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signature of Funeral Selvice Licensee 4107 WIlkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ESPIRATOR Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine DNGESTIVE that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical NFECTTOUS IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of perso who completed cause death (Item 23a) (Type, Print) KASHEE 1SICIAN

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State Registrar

31. Date filed (Month, Day,

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

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Department of Health a Important: If item 27 is any injury or other tra once,

Physician /Medical

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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral

Records,

Vital Physician:

Division or

and Mental Hygiene.

with

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dayth **Physician** ERMA CLAPPER DECEMBER 2007 Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2☑F Director July 10, 1918 219-36-0713 Vermont Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2302 Tucker Lane 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Self Employed Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Eldon Perry Leah May Shipley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane C. Lewis, Daughter 2302 Tucker Lane; Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 12/13/2007 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Juneral Service Lice <u> 1630 Edmondson Avenue; Catonsville, </u> Part . Liter the Jeas shock, or heart eilure. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a. Part . Enter the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EREPPOVAS CULAR THEOME OSIS /Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) malla mo D41410 December 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). In Gim best hoMEHTA 5 32 Registrar's Signature CENTER 2113 RAHDAUSTOWN MORTHWEST State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Brian Timothy Calvert** 2007 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day Year November 29, 2007 0719 hrs Medical Examiner Brian Timothy Calvert 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 20761 Old Great Mills Road Great Mills St. Mary's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Countr Florida 01/24/1966 523-35-0849 1 X M 2 41 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1 Yes 2 X No 28a-f show Great Mills st. Mary's MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants, If Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ouce. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20761 Old Great Mills Road 20634 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married No Specify: White 4 Divorced If Yes, Give Year Yes 2 X No specify: Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than event, the Medical MD 21215-0036 2 Mechanic Aircraft 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Magner Robert Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 S. Sherman Street, Longmont, CO 80501 Kathryn Calvert, Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) X Burial 2 Cremation 3 X Removal from State Foothills Garden of Memories 12/05/2007 Longmont, Colorado Other Specify Donation 5 22. Name and Address of Facility Lewellen Longmont Memorial Chapel Signature f Funeral ice License M01113 503 Terry Street, Longmont, Colorado 80501 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Hypertensive atheroscleratic cardiovascular diseas Immediate Cause (Final disease a. xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial -XUNPENDED AMENDED #23a.27.permE.g875 1/19/08 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 Nο 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other₄ examiner? Hospital: ER/Outpatient Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 3 1 V Yes Certification: To No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after acam.

To the Funeral Director: A 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 30, 2007

31. Date filed (Month, Day Year) State Registrar

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

Assistant Medical Examiner

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		13611 Demetrias Way			Germant			Montgomery	
Funeral Director		5. Social Security Number 6. Sex	,	(In yrs. last b		Year If Under 24Hrs. Days Hours Min.	1	MM/DD/YYYY) 9. E	eign
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		13611 Demetrias W	ау		2087	/4		United S	tates
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212. Ild be Mental marke event	To Be	Jean Paul Corrive		11	9b. Mailing Address (S			queline R	
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e, l l and Health item		20a. Method of Disposition		20b. Place	e of Disposition (Name of	f cemetery,	Date :	20c. Location - City	or Town, State
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7-09302 1ary Ruby Cha	apma	Please Type or Print in Black Inde State of Maryland / Departs	elible Ink. Ensure All Copies Are Le ment of Health and Mental Hygiene	gible.
, ,		Otato of Maryland / Boparti	icate of Dooth	eg. No. 2007 39891
Physic		Decedent's Name (First, Middle,Last)	2. Date of Dea	ath 3. Time of Death
Medical Exam ∱∷્	iner	Mary Ruby Chapman	Month Decembe	
		Facility Name (if not institution, give street and number) 10804 Livingston Road	4b. City, Town, or Location of Death Fort Washington	4c. County of Death Prince George's
Funera		Social Security Number 6. Sex 7. Age (In yrs. last b)		rth(MM/DD/YYYY) 9. Birthplace (State or
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21215-0036 Jud be filed within 72 hours after death with the Maryland Mental Hygiene The marked other than "matural", or items 23a or 28a-f shi ic event, the Medical Examiner must be notified at once	Be (David Smith	Nancy Ellen (Counts
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Division of Vital Records, tat or Attending Physician: The law requir as after death. al Director: After this certificate has been a led in by the funeral director, page 2 should led.	-	27 Manner of Death 28a Date of Injury 28th	b. Time of Injury 28c. Injury at Work? 28d. Describe	how injury occurred
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ivis lor At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home,	or Town.	(Street and Number or Rural Route Number, City State)
Divisior Hospital or Attend 24 hours after death. Funeral Director:		4 Homicide determined (Specify) Single Family 29a. Certifier 1 Continue Physician To the best of my knowledge.		ston Road, Fort Washington, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici con pletely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, and due to the cau or investigation, in my opinion, death occurred at the time, date	
To To CON	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Doma me incerti, m.D.	O.C.M.E.	December 8, 2007
9,		30. Name and address of person who completed cause of death (Item 23a		<u> </u>
		Donna M. Vincenti, MD Assistant Medical Examine	er 111 Penn Street, Baltimore, MD 21201	
Regis	itate strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Brails)	

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Janice D. Coche DEC. 2007 510 DM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 206 CRAIN COURT CR. ANNE ARUNDEL 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 □ M 2 X Yrs Director 226.46.3561 69 MAY 16,1939 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XXVo Director MD ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 206 CRAIN COURT CR. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CUSTOMER SERVICE REP. MVA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I nt: If Item 27 is marked of EDGAR C. MUSE JANICE M. TINSMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau 2498 McKENZIE RD. , ELLICOTT CITY, JOHN COCHE SON 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2) ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation BAYVIEW CHEMATORY INC. DEC. 11,2007 BALTIMORE, MD 21. Signature of Juneral Service Licensee FINK FUNERAL HOME, P.A. urec MOTT48 426 CRAIN HWY S., GLEN BURNIE, MD, 21061 23a. Part1. Enter the dise tse, or shock, or heart failure. List for tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cabse (Final disease or condition resulting in death) **Physician** /Medical mc Canar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other s 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an the funeral director, page 2 autopsy performed? (es 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21XNo 1 Tes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29h

DHMH 17 Rev 1/2001

State Registrar death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 2874 12-13-07 vt.
State of Maryland / Department of Health and Mental Hygiene 39898 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 610 AM Pauline 12 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗹 F Hours 69 Yrs 578-52-5339 05/14/1938 WASHINGTON D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGES LARGO MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA H103 9800 LAKE POINTS COURT 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PAUL HICKS WILLIE MAE DUKES ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1433 SOUTHERN AVENUE, =103, OXONHILL, MD 20745 estelle mitchell /cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ARDENTCREMATORY 12/11/2007 HANDVIER, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 7522 COSNELLEY DRIVE, N BQ HANOVER, MD 31076 ARBENTCHEMATIONSFRUICES Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 4 poxenia 10363 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** o morany Sequentially list conditions Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last car, signed by the attending physician and I be detached for use as the burial-transit of monony Due to (or as a consequence of): P.O. Box 68760. pan s Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120

DHMH 17 Rev 1/2001

State

Registrar

22

31. Date filed (Month, Day, Year)

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2007

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32. gistrar's Signature

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** December 8 2007 Robert E. Donohoe 10:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson 8. Date of Birth NOV. 1, 1945 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 62 Pennsylvania 177-36-7398 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director Md. N/A Baltimore City 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 100 Witherspoon Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Amed Foles: 1XYes 2□No 1f Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Principal Owner Almag Plating Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis D. Donohoe 2 Margaret Theuer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Teresa Donohoe/Wife 100 Witherspoon Rd. Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 12/17/07 ¢onshohocken, Pennsylvania 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventriculus Arrhy mms. **Physician** /Medical Due to (or as a consequence of): Examiner HUBERTENSUF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown cate has been signated by Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation ne Hospital or At., hours after death. ral Director; AF in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

1541

Registrar

31. Date filed (Month, Day, Year) DEC 1 3 2007

29b. Signature and title of certifier

studi stust

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

one)

M.D ,901 32 egistrar's Signature

Fort tw. haltimore, MD 21230 E.

29c. License number

1239660

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Wilcox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2104020c. Location - City or Town, State Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death DISSOCIATION 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 260, GATEWAG DRIVES 411621 32. Registrar's Signature ORIGINAL

10:50 AM

Birthplace (State or Foreign Country)

North Carolina

10d. Inside City Limits

1 □ Yes 2X No

Harford

14. Race - American Indian

White

Black, White, etc.

USA

Specify

10

State Registrar ANUSHA STRITHARA

1

31. Date filed (Month, Day, Year)

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F		13	RegIstrar 1. Decedent's Name (First, Middle, Last)		001	incate or i	Jean	2. Date of Dea	Reg. No.		3. Time of Death
*	Physicia /Medic		ELSIE LEE DO	ORSEY				Month Decembe	er 7,	Year 2007	10:55 p M
	Examin		4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, or	Location of Death			ounty of Death	
			Mariner Health Care of La			Laurel					eorge's
l	Funeral Director		220-18-8550 1 M 2 T F	Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Oct. 1]	r, Year)	Cou	place (State or Foreign ntry) Yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Many I-f sho fied a	tor	Maryland Howard	Laure	1						1 □Yes 2□No
	h the or 28a e noti	Director	10e. Street and Number	Daure		10f. Zip Code			10g. Citizer	n of What Cou	
	tth wit		8414 Leishear Road			20723			U.S.A	A.	
36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes, Give	s? Mo		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen) In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White pecify:	, etc.
Ö	tural'	ed b	3XXVidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education		. Deced	ent's Usual Occupa	ation			of Business/Ir	lite
5	nin 72 n "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o		(Give :	kind of work done of OO NOT use retired	turina most of work	ng	TOD: TUITO	Of Businessin	iodatiy
212	filed with Hygiene other tha snt, the I	Completed	Grade 12		ook!	keeper			Depa	artment	Store
nd	12 should be filed w h and Mental Hygie 7 Is marked other ti raumatic event, th	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			ırname)	
<u>₹</u>	ould I Men narke	은	Frederick Carr				Bernice				
<u>a</u>	d 2 sho th and ?7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print) Nancy Ryan / daughter				and Number or Rura Great Cac				,
<u>ი</u>	Heal Heal Hem 2	1	20a. Method of Disposition			sition (Name of natory or other place		Date		tion - City or T	
e E	Pages nent of int: If its iny or o		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	e i		cemetery.		2/2007	Scago	gsville	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If if any injury or o		21. Signature of coneral Service Liouve		22	Name and Address	s fineral	Home, H	P.A.		-
	20 = 20		GS GA	M00770			tt Avenue			aryland	20707
	Physician		23a. Part1. Enter the disease, or complications that caus shock, or head failure. List only one cause on each Immediate Cause (Final disease or condition	ed the death. Do line. age Deme			g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death 3-6 months
	/Medical Examiner			as a consequence							2
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	nsit 🚧 ife	Examiner	cause. Enter Underlying	le Decub		s Ulcers					3 months
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	ertifica ling ph e as t		IF FEMALE:								
C. Box	the death certifi y the attending iched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death at time of death		Ectopic pregnancy Other (specify)			23d	d. Date of delive Month	rery Day Year
as, F	res t	þ	Part II. Other significant conditions contributing to death $HTN \label{eq:hamman} \label{eq:hamman}$	but not resulting in	n the un	derlying cause give	en in Part I.				the cause of death?
ecord	law require as been sig 2 should b	lete	Failure to Thrive					24a. Was a	an 2	24b. Were aut	opsy findings available
r	sician: The lav certificate has rector, page 2:	Completed							sy rmed? 2CXNo	prior to co death? 1 ☐ Yes	ompletion of cause of 2XXNo
VItal	sician: certifica irector, p	BeC	25. Was case referred to medical examiner?				26. Place of Death				-A27/0
2	Physic this co	户	1 ☐ Yes 2/CXNo Hospital: 1 ☐ Inpa	tient 2 ER/Ou	<u> </u>		4 EMANUISING HO				fy)
	Attending Physician: r death. ector: After this certific by the funeral director,	ion:	27. Manner of Death 1		Time of Injury	28c. Injury Work	/at d? Yes 2 □ No	28d. Describe h	ow injury o	ccurred	
UNISION	i or Attendi after death. Director: A in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of investigation	njury - At home, fa	arm, stre			 28f. Location (S	Street and N	lumber or Rui	al Route Number,
2	ai or / s after il Dire d in b	Certification:	4 Homicide determined building,	etc."(Specify)				City or Tow			
		Medical C	29a. Certifier (Check only one) 1 X Zertifying Physician: To the besis and manner: and manner.	of examination an	e, death	occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the dred at the time,	cause(s) an date and pla	nd manner as a	stated. to the cause(s)
	ro the vithin ro the comple	Med	29b. Signature and title of certifier	7,0,100.		29c. License	number		29d. Date s	igned (Month,	Day, Year)
	2 - 0		formera no			D 5	7216		Decem	mber 11	, 2007
	6		30. Name and address of person who completed cause of								
)				Road	d, Suite	209, Laui	cel, Mar	ryland	2072	.4
	Sta Registra	_	31. Date filed (Month, Day, Year) DEC 1 3 2007	strar's Signature	dea	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:00 P M December 10, 2007 Gordon Raymond Earley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Caton Manor Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 21, 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1921 Maryland 86 216-07-8974 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 2911 Stafford Street 21223 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No White Baltimore, Maryland 21215-0036 Specify 3 X Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packer Stee1 ilth and Mental Hygie 27 is marked other i r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Thater Samuel K. Earley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tra 2911 Stafford Street; Baltimore, MD 21223 Raymond S. Earley Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/13/2007 Baltimore, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Septi 1401290 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line.

Immediate Cause | Final Approximate Interval Between Onset and Death ADVANCE DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ VIcers 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: A in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🔨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of ca 29d. Date signed (Month, Day, Year) Doc62634 and a ress of person who completed cause of death (Item 23a) (Type, Print) HICKORYRIDGE RD COLUMBIA 10802 21044 MATEEN A. AWAN 31. Date filed (Month, Day, Year) ♣32. Registrar's Signature State Registrar DEC 1 3 2007

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REBA G	or Vital
	ivision

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2007 399	03
Physicia /Medic		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 7:10	
Examine	- 2	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral Director	Ž.	Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8. G. 1935 9. Birthplace (State or Country) YA	Foreign
land ow ft		Usual Residence of Decedent 10a. State	Limits
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leath with the Marylan ns 23a or 28a-f show must be notifiled at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A 12 Was December Ever in U.S. 13 Was December of Hispanic Origin? (Specify Yes or No) 14. Race - American Indian,	
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. If Heath and Mental Hygiene. other Tris marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notitied at	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No Specify: Specify: Black	
15-0	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Sive kind of Work done during most of working life. DO NOT use retired)	
2121 ed within ygiene. er than "	Som D	Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Services	5
land 2	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Woodson	
Maryland Id 2 should be flie Ith and Mental Hy Z7 is marked oth traumatic event	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, Ma 1 and 2 Health a em 27 is		Michalle Gregory/Daugnter 9F Hogarth Cir. Coc Keysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
0 0		cemetery, crematory or other place)	
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe one.		2 Communication 3 Herroval Horn State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Varying C. Greene Funeral Service 4905 York Pd Baltimore, MD 21212	కు
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	een
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	cs_
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	Examiner	Tally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
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Box sath cer	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \(\bar{\textbf{N}}\text{No} \) 9 \(\bar{\text{Unknown}}\text{Unknown}\)	ear
or Vital Records, P.O. Physician: The law requires that the de r this certificate has been signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 XIV	eath? nknown
Reco e law rechas bee	Completed	24a. Was an autopsy performed? 24b. Were autopsy findings a prior to completion of ca	vailable use of
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r Vita	To Be	25. Was case referred to medical examiner? 1 Yes 2x No	CE
ing ing	On: T	27. Manner of Death 1 ▼ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred	
Division or Vita or Attending Physician: affer death. Director: After this certification by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Rural Route Number	er,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	ledical Co	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To th within	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December (1)	2007
1		30. Name and oddress of person who completed cause of death (Item 23a) (Typ), Print) De Ernestine Weisht Stelly Malis 2300 Winey Valley &	22
Sta Registr		31. Date filed (Month, Day, Year) BEC 13 2007 31. Date filed (Month, Day, Year) 32. Registrar's Signature Timunium, MD 3 7673	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? (1)

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			1 - State Registrar		Certificate of	Death	Reg. No.
	Physici	an	1. Decedent's Name (First, Middle, La	F Goetz		2. Date of I	Day Year
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, o	Delem Delem or Location of Death	4c. County of Death
				pital	Balti last hirthday) If Under 1 Year	more	N/A
	Funeral Director		5. Social Security Number 6. S 220-78-6126 1 Usual Residence of Decedent	Pex 7. Age (In yrs. la	Yrs. Months Days	Hours Min. (Month, L	9. Birthplace (State or Foreign Country) 8, 1961 Maryland
	ryland how	_	10a. State 10b. County	10c. City	y, Town or Location	_	10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland N/A 10e. Street and Number		Baltimor	e 	1 ▼Yes 2 No 10g. Citizen of What Country?
	ath with t			Fourth Street	10f. Zip Code	21225	USA
Maryland 21215-0036	be filled within 72 hours after death with the Maryland ital Hyglene. I have a consistent than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🎇 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	S. 13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 21 No	dispanic Origin? (Specify Yes or I lan, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15-0	n 72 h "natu edical	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working id)	16b. Kind of Business/Industry
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pu	be filed ttal Hygi d other event, tt	Be	17. Father's Name (First, Middle, Last,			18. Mother's Name (First, Midd	· ·
ryla	Mer Mer arke	욘	Jacob Unari 19a. Informant's Name/Relationship (es Goetz, Jr.	19h Mailing Address (Street	Marie Eliza	Detn Koss
	오프었는		Mark Goetz, Sr.	(Brother)	1	ton Ave., Glen	
Baltimore,	of of		20a. Method of Disposition 1 Mag Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	Place of Disposition (Name of lemetery, crematory or other placen Haven Mem Placen		20c. Location - City or Town, State Glen Burnie, Maryland
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	nsee Kevin E Ecke	er McCully-F 237 E. Pa	Polyniak Funeral atapsco Ave., Ba	Home, P.A. ltimore, Md. 21225-185
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. Hypogly Due Wrasa risehu	n. Do not enter the mode of dyi uence of):	ng, such as cardiac or respiratory	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Medical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetes Due to (or as a consequence)	uence of):		laaif
.O. Box	ires that the death cert signed by the attendin be detached for use i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnal 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	I death 3 ☐ Ectopic pregnand	у	23d. Date of delivery Month Day Year
S, P.	es that igned k	by P	Part II. Other significant conditions	. 1	11		d tobacco use contribute to the cause of death?
ord	w requir been si should	eted	nacolados D,	repairis C	Heparic		Yes 2 No 3 Probably 4 ☑ Onknown
or Vital Records,		Completed	encephalogas	w, CM110	0212 .	24a. Wa au pe 1 Yes	topsy prior to completion of cause of death?
. Vit	Physician: this certific	o Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 1	ER/Outpatient 3 DOA Ott	26. Place of Death (Check only her: 4 ☐ Nursing Home 5 ☐ Re	y one) esidence 6 □Other (Specify)
o uo	ng ifter	ion: T	27. Mann of Death 1 atural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Mo		e how injury occurred
Division	or Attending after death. Director: After din by the funer	Certification:	2 Accident 3 Suicide 4 Homicide 2 Could not b determined	e 280 Place of injury. At ho	ome, farm, street, factory, office	28f. Location	(Street and Number or Rural Route Number, own, State)
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occurred at the t tion and/or investigation, in my	ime, date and place, and due to the opinion, death occurred at the time	ne cause(s) and manner as stated. le, date and place, and due to the cause(s)
		Me	29b. Signature and title of certifier Sahar Kol	ranum, MD	0.4	se number	29d. Date signed (Month, Day, Year)
	3						hmae MD 21225
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2	32 Aegistrar's Signat	ture species		

amend item 4c state domary and Debas 7 ment of Health and Mental Hygiene Certificate of Death 39905 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dec 7, 2007 Ann Gentry 12:22 AM /Medical 4a. Facility Name (If not institution, give street and number) County of Death
Anne Arundel 4b. City, Town, or Location of Death Examiner 31 Lincoln Parkway Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1935 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XX 229 44 1730 Director Sept 20.1985 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at anone. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√TNo Director Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 12508 Parker Lane 20735 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: 3. Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ju<u>venile Officer</u> State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sumner Barge Willie Evelyn Langley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollis Gentry (Daughter) 1500 Mass Ave NW, Washington, DC 20005 #364 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Resurrection Cemetery 12/15/2007 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Buneral Service Licensee Ferry Road, Clinton, Md 20735 <u>Alexandria</u> 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** CANCER OF THE LUNGS disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 M No 23d. Date of delivery 3 DEctopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes after death. **Director:** After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SISTER'S 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOME Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ameandown MD D16619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUARE DR. BALTINODE MD 91291 VERGARA-SOA 31. Date filed (Month, Day, Year)
DEC 1 3 State 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar	Middle			Ce	rtificate of	Death		. Date of Dea	leg. No.2	107	3990
sician	1. Decedent's Name (First,	Gourdi	n						Month ECEMBE	Day	2007	10:09 A
ledical aminer	4a. Facility Name (If not ins		••	nber)		4b. City, Town,	or Location o				nty of Dea	
	GREATER BA					TOWSO		0411-			LTIM	
eral etor	5. Social Security Number 062-28-0076 Usual Residence of Deced		M 2□F	7. Age (In yrs. 79	Yrs.	Months Days		Min.	Date of Birth (Month, Day	, Year)	Co	thplace (State or Fo ountry) Belgium
Director	10a. State 10b. 0	County 1timore			y, Town or Lo	ocation						10d. Inside City L 1 ☐ Yes 2
ral Dire	10e. Street and Number 1217 Robii					10f. Zip Code 21204				10g. Citizen of What Country?		
Lexaminer must be notified at I by Funeral Director	3 ☐ Widowed 4 ☐ Div	X Married	 Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da 	2 X No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 No	ban, Mexicar	gin? (Specif i, Puerto Rid	fy Yes or No- can, etc.)		lack, Whit	erican Indian, te, etc. White
any injury or other traumatic event, <u>me medical Exa</u> once. To Be Completed by	15. De (Specify only Elementary/Secondary (ecedent's Educa highest grade 0-12)	completed) College (1	-4or 5+)	i (Give	dent's Usual Occu kind of work done DO NOT use retire Director	e during most ed)	t of working			Business t-Hen i ne	•
To Be C	17. Father's Name (First, M	^{Middle, Last)} urdin					18. Mothe	r's Name <i>(F</i> Theres		Maiden Surna QUY		
	19a. Informant's Name/Re Barbara Gou		,		1217	ng Address <i>(Stree</i>		rcle,	Towsor	-	vn, State, . 212	
ury or our	20a. Method of Disposition 1 ☐ Burial 2 ☑ Crem 4 ☐ Denation	nation 3 □Re	emoval from S	State C	emetery, crei	osition (Name of matory or other place)	1 1	Date 2/12/2	1	Zoc. Location	•	•
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State Registrar

DHMH 17 Rev 1/2001

CEORUS KARKAR MO JA, 65
31. Date filed (Month, Day, Year).

32. Pegistrar's Signature

Spark! ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. amend item 26 Meriano Desartinent of Health and Mental Hygiene 1- State AMEND ITEM/17, perFH, G874, 12/20/07, We ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Earl W. Hampshire 2115 hx M December 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Himore St. agnes n/a 5. Social Security Number Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 / 20 / 1938 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **1**X M 2□ F 216-34-5404 Yrs. 69 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 X No MD Halethorpe Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1920 Victory Drive 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Transport Driver 17. Father's Name (First, Middle, Last)

Earl S. Johnson 18. Mother's Name (First, Middle, Maiden Surname) Viola Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Hampshire/ Wife 1920 Victory Dr., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Bayview Cremaory 12/15/2007 Baltimore, MD 21. Figurature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orale Due to (or as a con, equence of) 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Poli Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dr.R. POLA

Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Division or Vital

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

filed within 72 hours after death Hygiene.

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other thu any Injury or other traumatic event. th-

Physician

/Medical

Examiner

and

attending physician for use as the buria

ed by the a

signed I

sate has t

certificate be executed

Box 68760,

P.0.

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Ristrar's Signature

AS 2438528

400 St. agnes Hospital,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Huffman December 8, 2007 5:30 Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 12, 1 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Days Yrs. **Director** 1940 219-38-5161 Maryland 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 28a-f show notified at 1 □Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? a or ral", or Items 23a Examiner must b U.S.A. Funeral 887 Woods Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: 3 XWidowed 4 ☐ Divorced White "natural" the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) 12 N/A Accounting Clerk other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mcther's Name (First, Middle, Maiden Surname) Be and Mental Is marked ဥ Rosalie Bottinger Kirsch Christian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 5:30 : If Item 27 I Jeanne A. Bair (Niece) 5319 Airport Drive White Marsh Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo 1 Buriai 2 □ Cremation 3 □ Removal from State Department or Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 12/12/07 Brooklyn Park Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Ignan months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): or Vital Records, P.O. Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetai death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by as been si 2 should b 1 ☐ Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate 2 2 No the Hospital or Attending Physician: rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural MARGARET M 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ည 52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRIGHT, ERNESTINE 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month DEC Deale State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nomas nomes		- For State Criviary and 7 Department of Health and Mental Hy		1. No. 200	7 39909
Physician	n/		2. Date of Death Month		3. Time of Death 0834 hrs
Medical Examin	er	THOMAS Lee Warren Holmes 45. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month December	5, 2007 4c. County of Deatl	
1		Franklin Square Hospital Rosedale		Baltimore Co.	- 1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	_	(MM/DO/YYYY) 9. Bi	thplace (State or Foreign
Director		217-76-6032 1x M 2 F 42 Yrs. Months Days Hours Min. Usual Residence of Decedent	12-28-	Ma	ryland
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show	۱	MD Baltimore Middle River			1 Yes 2 XNo
Maryl:	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
th the 23% or notifie		2217 Coralthorn Rd 21220		SA	
re, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,
s after ral", niner	≥⊦	3 Widowed 4 Divorced If Yes, Give Year or Dates:	and done	Specify Blad	ck
hour. "natu	틸	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business	industry
336 thin 7, re. than edical	Completed	12th Car Detailer		Private	
5-0(led wi tygier other	ទី	17. Father's Name (First, Middle, Last) 18. Mother's Name	•	aiden Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene Revent, the Medica	a	Thomas Lee Holmes Linda P			
MD 2 d 2 should lih and M n 27 is m	-1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			
imore, MD 2 Pages 1 and 2 shou ment of Health and In land: If item 27 is no or other traumatic		Linda Ahins/Mother 2217 Coralthorn Rd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Date Date	20c. Location - City o	Town, State
More Pages 1 nent of H ant; If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place)		D-1+:	- MD
Baltimore, permit. Pages la Department of the Important: If the injury or other tr	1	4 Donation 5 Other Specify: Mt. Zion Cemetery 12-			
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep	-	Jalens + Rah 108 W. North Ave	. Balt.	aylorII F imore,MD	H 21201
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Cardiomegaly complicated by infectious en	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	İ	Immediate Cause (Final disease or condition resulting in death) a. Hytertensive cartisvareules disease Oue to (or as a consequence of):			Death
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	Examiner	if any, leading to immediate Oue to (or as a consequence of): cause. Enter Underlying Cause C.			
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rtificating ph	an/s	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ancy	Month	Day Year
Box 687 e death certifice the attending p ed for use as th	/sician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown			
the de by the ched f	EL	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.O.	<u> </u>	Cocaine use	1 Yes	2 No 3 Pro	obably 4 🗸 Unknown
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e law e law e has l	립		autop perfor 1 ✓ Yes	med? death?	
l Re n: Th tificat or, pag		25. Was case referred to medical 26.Place of Death (Check		2 140	65 2 10
Vita ysicia his cel direct	To Be	examiner?	ng Home 5	Residence 6 Oth	er:
Division of Vital Records, tal or Attending Physician: The law require rs after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director.	֡֡֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֟֡֓֓֓֓֓֡֓֓֓֡֓֓֡	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
ion ttendi death. ttor:	읡	1 X Natural 5 Pending 2 Accident Investigation 1 Yes 2 No			
ivis lor A after Direct	Certification:	3 Suicide 6 Could not be determined (Specify)	28f. Location (S or Town, S		tural Route Number, City
ospita hours uneral		4 Homicide 29a. Certifier A Country State and	due to the enus	o(s) and manner as st	atod
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date	and place, and due to	the cause(s)
E > E S	8	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		famele wednell ned O.C.M.E.		December 6, 20	007
		30. Name and eddress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201		
Sta	17.	31. Date filed (Month Ballyan) 3 2007 32. Restrar's Signature			
Registr	ar	The same of the sa	· · · · · · · · · · · · · · · · · · ·	 	

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9, 2007 **Physician** December Evelyn White Horst /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Months 1 □ M 2**X** F 95 Director 218-28-2156 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1055 W. Joppa Road, Apt. 635 21204 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and 2 should be filed within 72 hours after lealth and Mental Hygiene. m 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Joseph Asbury White Caroline Bringmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau Ken B. Gore - grandson 3710 E. Baltimore Street, Baltimore, MD 20a. Method of Disposition

1 Burial 2 Coremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Metro Crematory, Inc. 12/10/2007 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Steven H. Williams Name and Address of Eacility.
Cremation Society of Maryland, Inc.

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

after death.

I Director: A
d in by the fu

Examiner Physician/Medical þ Completed Be Certification: To Medical

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

1 Natural

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

9□Unknown

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Bradylozdic

Due to (or as a consequence of):

Due to (or as a consequence of)

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 23d. Date of delivery Month

24a. Was an eutopsy performed

299 Frederick Road, Baltimore, MD

23e. Did tobacco use contribute to the cause of death? 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes

1 ☐ Yes 2 ☐ No

39910

2:05 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 nour

Year

1 □Yes 2XNo

Maryland

USA

Specify:

Black, White, etc.

White

24b. Were autopsy findings available prior to completion of cause of death? 2 NO 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred

(Month, Day 5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month. Dav. Year) 10,200+ ember

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, DEC 1 3 2007

Registrar DHMH 17 Rev 1/2001

State

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After

within 24 hours a To the Funeral C To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	or Mary	yiand /		rtificate of			птат ну	gien Reg. No	2007	3991	
	Physici	an	1. Decedent's Nam	e (First, Middle, La	ast)						2.	Date of De Month	ath Da	ay Year	3. Time of Death	
	/Medic			A. Jaco								ec.	11	2007	11:40 A M	_
	Examir	er	4a. Facility Name (-	ve street and nu	mber)			4b. City, Town,		of Death		40	c. County of Death		
-		4	Gilchris 5. Social Security N		Sex	7. Age (I	In yrs. last t	irthday)	Towso:		er 24 Hrs. 8.	Date of Bir	th	Baltimo	nplace <i>(State or Foreigr</i>	
	Funeral Director		016-40-4	671	1 M 2 □ F		57	Yrs.	Months Days		Min.	Date of Bir (Month, Da arch	iv, Year	50 Mass	sachusetts	
	aryland show d at	_	10a. State	10b. County		10	0c. City, To	wn or Lo							10d. Inside City Limits	
	ne Ma 8a-f	Scto	MD	Baltim	ore					ockey	sville					
	leath with the Marylar ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Nu 938 Waln	mber nutwood R	d.				10f. Zip Code	21030			10g. C	itizen of What Cou USA	Intry ?	
	r dea	ne.	11. Marital Status		12. Was Dec Armed Fo	orces?	er in U.S.	13.	Was Decedent of If Yes, specify Cul	Hispanic C ban, Mexic	origin? (Specit	y Yes or No an, etc.))-	14. Race - Amer Black, White		
036	filled within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	ð	1 ☐ Never Mari 3 ☐ Widowed	ried 2 🕅 Married 4 ☐ Divorced	1 [X]Yes If Yes, Gi Year or D	2 □ No ve ates: 6	8'-74		1 □ Yes 🏖 No						nite	
15-0	s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	Completed		15. Decedent's E	ade completed)		16	a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	ost of working		16b. I	Kind of Business/I	ndustry	
212	f withi jiene. r than	mo di	Elementary/Seco	ondary (0-12)	College (1-4or 5+) 4			etail Ma					Retail		
و	e filec al Hyg othe	BeC	17. Father's Name	. Father's Name (First, Middle, Last) 18. Mother's Name							her's Name (F	irst, Middle	, Maide	n Surname)		
<u>a</u>	uld be Jental rked o tic eve	To E	Gunnar J. Jacobson Charlotte Burleigh													
2	2 should and Men is marke aumatic		Gunnar J. Jacobson Charlotte Burleigh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									ip Code)				
2	and and and and and and and and and and			Jacobso	n/wife						., Coc	keysv		e, MD 210		
o km Baltimore, Marvland 21215-0036	Pages 1 annent of Hee			position XCremation 3 [5 □ Other (Spec		State		o Cr	osition (Name of matory or other pla ematory	1	December 15, 20	07			imore MD	
11 40 In orm ■ Balt	permit. Pages Department of I Important: If ite any injury or of once.		21. Signature of F					Lo Lo	2. Name and Address emmon Fur 0 W. Pade	ess of Fac neral onia	Home (of Dul	lane	y Valley MD 21093	, Inc.	
=	Dhysisian		23a. Part1. Enter shock, or hea	the disease, or cor art failure. List only (Final		caused the each line.	e death. D	not ent	ter the mode of dy	ing, such a	as cardiac or r	espiratory a	irrest,		Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition resulting in death)	on	a Due to	(or as a c	onlequenc	- 7	eal c	MYCC				-	Jeans	
12/11/07	A PROPERTY.	ner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or that initiated event	onditions, nmediate	b. Due to	(or as a c	onsequenc	e of):								
2/13	ecuted and I-transi	xami	Cause (Disease or that initiated event resulting in death)	injury s Last	c	(or as a c	onsequenc	e of):								
165 17605c	tificate be executed g physician and as the burial-transit	edical Examiner			d											
176 176			IF FEMALE:									77.7				-
Char O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/N	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	? months? □ No		birth 2 [nant at tim	pregnancy □ Fetal dea ne of death		⊒Ectopic pregnan ⊒ Other <i>(specify)</i> _	су			10	23d. Date of deli Month	ivery Day Year	
Son,	res that igned by		Part II. Other signi		1	/	-		nderlying cause g	iven in Par	t I.			_	the cause of death?	_
900	requi	eted	097 W	v dine		7 ach	0 0,00									
Division or Vital Records. P.O	sician: The law certificate has b irector, page 2 s	Completed by										24a. Was auto perfe 1∐ Yes	psy ormed2	death?	topsy findings available completion of cause of 2 ☐ No	9
Vita	Attending Physician: r death. ector: After this certifics by the funeral director, p	Be	25. Was case refe examiner?	/	Hospital:					hor.	ce of Death (0				1/	
9	Phys er this eral dii	<u>۲</u>	1 ☐ Yes 2 ☐ 27. Manner of Dea		28a. Date			. Time o	" 3 DOA	4 🗆 1				6 ☐Other (Specury occurred	city) Huspice	_
on	nding th. :: Afte	tion	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending Investigation	,	nth, Day Y	'ear)	Injury		ork?]Yes 2[- 1					
Divis	of a death after death I Director: of in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	20e. Place	e of injury ling, etc. (- At home, 'Specify)	farm, str	reet, factory, office		28f	Location (City or To	Street a wn, Sta	and Number or Ru te)	ural Route Number,	
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)		miner: On the b		my knowled kamination d.	ge, deat and/or in	h occurred at the evestigation, in my	time, date opinion, d	and place, and leath occurred	d due to the at the time	cause((s) and manner as and place, and due	stated. to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and	title of pertifier	2	A. i	2,_	m	29c. Licer	se number	35		29d. D	ate signed (Monti	h, Day, Year)	
	941		30. Name and add	ress of person who	completed cause	se of deat	th (Item 23a) (Type,	Print)	0 0	, . CL	e . V	2x.	m12:	stated. to the cause(s) h, Day, Year) //, 200,2	
	,	•	31. Date filed (Mor	nth. Dav. Year)	1 6 9	Registrar's	Signature	101	M. C		- 7/1	1/00	70.	0 21		
	Sta Registr		OT. Date field (1910)	nec 1	3 2007	A Charles	ers h	K	Coules							

			1 - For Stata Registrar	State of Ma	aryland / Depa <i>Cei</i>	tificate of L		, ,	. No.	07712	
	Dhusisi		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medio		Jan Michael Job	anek				December		12:20 PM	
\$- -	Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, or	Location of Death	1	4c. County of Death		
			1724 Whitfield	Court		Croftor	-		Anne Arund	le1	
	Funeral			Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	place (State or Foreign unknown	
	Director		227-56-8109	122 M 201	65 Yrs.			April 6,1		dirkilowii	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation			1	0d. Inside City Limits	
	Aanyl Feho	ō	M1 A A	1 - 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 ☐ Yes 2 X No	
	28a-	Director	Maryland Anne A	runaeı		Crofton 10f. Zip Code		1.00	0::		
	with a	ā					11/	109	. Citizen of What Cour	•	
	eath	era	1724 Whitfield Co	12. Was Decedent I	Everin U.S. 13 V		114	necity Ves or No-	United St		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event. It a Madical Exacidant must be inclined at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 1 N If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2\\\ No	Specify:	o Rican, etc.)	Black, White,		
Ŏ	2 hou	ted	15. Decedent's E	ducation	16a. Deced	ent's Usual Occupa	ition	16	b. Kind of Business/In		
2	hin 7	Completed	(Specify only highest gi	ra <i>de completed)</i> College (1-4or 5	(Give	kind of work done d OO NOT use retired)	uring most of wor	king		•	
7	giane er th	Som	Zioniania, socondally (5 12)	5+		sultant			Air Saf	ety	
덛	al Hy al Hy doth	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)		
<u>Ja</u>	Ment Ment arkec	ပ္	Wilbur L.	Jobanek			Mary	Ann			
a	and and seum		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Number, C	city or Town, State, Zip	Code)	
≥ .	and ealth n 27		Robert S. Dodd/fi	iend		Grandview		Gambrill	s, Marylan	d 21054	
ore	of H.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date 20	c. Location - City or To	own, State	
Ξ.	Peg ment ant: ury c		4 □ Donation 5 □ Other (Spec	fy)	W. Arunde	1 Cremato	ry 12/1	1/2007	denton, Ma	ryland	
Baltimore,	Depermit Depermit Import eny In		21. Signature of Funeral Service Lice	Homas	- D		Funeral		rematory, F on, Marylan		
			23a. Part Lenter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do not ente					Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	Anu	to Am	diac.	145	CSIT.	0,0011	Onset and Death	
П	/Medical		resulting in death)	Due to (or as	a consequence of):	CUTIF	Alo.	217161	reg		
	Examiner		Sequentially list conditions,	b. Hy	no vole	WIA					
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (/ as	consequence of):	1 1	1 2	1.	,		
	ifficate be executed g physicien and as the burial-transit	(an	Cause (Disease or injury that initiated events resulting in death) Last	c. 0A5	+ roint	CSTINA	17	emorr	haze		
တ္ထိ	be ex		and the second s	Due to (or as a	a consequence of):						
68760	cate t	edical	•	d							
9 ×	ding p	₩e	IF FEMALE:	22a Huga automa							
Вох	iaw requires that the death certifias been signed by the attending 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of delive Month	ory Day Year	
o	w requires that the de been signed by the a should be detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				,	
J.	that t	F	Part II. Other significant conditions	contributing to death bu	ut not resulting in the un	deriving cause give	n in Part I	23e Did tobac	co use contribute to the	ne cause of death?	
Vital Records,						our, my dasse give	The control		2 No 3 Prob		
ŏ	y requ	Completed									
ĕ	0 - 0	d E						24a. Was an autopsy performed	prior to cor	psy findings available npletion of cause of	
<u></u>	certificate hi							1 ☐ Yes 2		2□ No	
=	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Otho		th (Check only one)			
ō	y sign	2	1 A es 2 No 27. Manner of Death	1 Inpatie			+ □ Ivuising no		e 6 □Other (Specify	()	
	ding Ph h. After th funeral	E l	1 Natural 5 ☐ Pending	(Month, Day	Year) 28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred		
Division	Attending ir death. ector: After by the fune	Ca	2 Accident investigation 3 Suicide 6 Could not be	Offic Place of Injur	ry - At home, farm, stre		es 2 □No	79f Loanting (Street	et and Number or Rura	1 Court thank	
-	ital or Attendir us after death. ral Director: Af	Certification:	4 Homicide determined	building, etc	(Specify)			City or Town, S	State)		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier 1 Certifying Place (Check only one)	nysician: To the best of miner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)	
	To With	Σ	29b. Signature and title of certifier								
•			Mellen	Kh	2, mg	DE	06054	f ca Ct	12/6/7	7	
1	241		30. Name and address of person who	completed cause of de		Print)	1	A 1	, , ,		
- 1	7									· ·	
	4		31. Date filed (Month, Day, Year)	JONES	mo (95 /	meri	ca Ct	. 2103	5	

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice To the

> 0, State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Eskander 501 Elhamy MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

D 48/84 | 12/11/07

The street Frederick MD 2/70/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Month **Physician** Decembe Ok Hui Ko /Medical 4a. Facility Name (If not institution, give street and number)
BOITI MORE WASHINGTON MEDICAL HET 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Anne BURNI 8. Date of Birth
June 22, 1925 5. Social Security Number If Under 1 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 82 Months Hours Min. 1□ M 2X F Korea 241-27-9668 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director NY Queens Maspeth 10e Street and Number 67-41 64-41 52nd Avenue 10g. Citizen of What Country? 10f. Zip Code United States 11378 Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No if Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Asian 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yong Hwan unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any Injury or other trau Mary Chun, Daughter 67-41 52nd Avenue, Maspeth, NY 11378 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Crematory 12/13/2007 East Elmhurst, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward D. Jamie Funeral Chapel 21. Signature of Funera M01113 14126 Northern Blvd., Flushing, NY 11354 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, <u>Ş</u> pe 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 20 No page 26 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ZiNatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: Division the Hospital or Attending 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death. nin 24 hours after death the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D0032 dulla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nnaemeka Agajelu, MD 1411 Madison Park Drive, Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 3 Registrar's Signature State DEC 1 3 2007 Registrar

	Examir Funeral Director	7	217-22-0625		Age (In yrs.	last birthday) Yrs.	Essex If Under 1 Ye Months Da	ar If Ur	nder 24 Hrs. urs Min.		rth ay, Year)	Cou	place (State or Foreign intry) 1sylvania
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show any injury or other treumatic event, the Modical Exertification be resulted at ance.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin	nore		ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2X No
	or 24	Dire	10e. Street and Number				10f. Zip Cod				•	n of What Cou	ntry?
	ter death v Itams 23a	by Funeral Director	5822 Lyt1e Rd 11. Marital Status 1 Never Married 2 Marrie	12. Was Decede	es?	.S. 13.	21162 Was Decedent of If Yes, specify C	of Hispani	c Origin? (S xican, Puer	pecify Yes or No o Rican, etc.)	U.S	· A · · Race - Ameri Black, White,	
-0036	Phours af	ed by F	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:	16a. Dece	1 ☐ Yes 2X 1	cupation	ecify:			pecify: Whi	
21215	d within 7%	Completed	(Specify only highest Elementary/Secondary (0-12) 10	grade completed) College (1-4	or 5+)	(Give life. Te11e	kind of work do DO NOT use re	ne during ired)	most of wo	rking		king	,
Maryland 21215-0036	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, L Michael Gerzanio							ne (First, Middle Scubanic		umame)	
, Mary	and 2 sho salth and h n 27 is ma ar treuma	•	19a. Informant's Name/Relationsh George Koerner	ip (Type, Print) (Son)		1	-			ural Route Numb arsh, MD			Code)
ore	iges 1 of of He or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		ate c	cemetery, crei	osition (Name of matory or other	olace)	100	Date		tion - City or T	
Baltimore,	permit. Pa Departmer mportent iny injury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service D		Но	22	11 Mem.	dress of F	acility Sch	08-2007 nimunek zimore,	Funer	al Home	Maryland
	Fny sicia n /Medical Examiner	ler	23a. Part1. Enter the disease, or or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter or Jorythn	a Due to (or	h we.	th. Do not ent	er the mode of	tying, suc	h as cardia				Approximate Interval Between Onset and Death M- KNWM
68760,	icate be executed physician and s the burial-transit	edical Examiner	cause, Chief or Jorying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	juence of):							
Вох	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2∏Feta tattime of d	Il death 3	Ectopic pregna Other (specify,				236	d. Date of deliv Month	ery Day Year
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant condition	ns contributing to deal	h but not res	culting in the u	nderlying cause	given in P	ent 1.		tobacco use Yes 2 🗆		the cause of death?
Division of Vital Records, P.O.	Physicien: The law re r this certificate has bee ral director, page 2 sho	Completed	_ Areni -	Congest	ive Hea	rt Failu	ire			1 ☐ Yes	psy ormed? 2 No	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
<u> </u>	sicier certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes = 2 ☐ No	Hospital:	ationt 2	ER/Outpatier	nt 3 DOA			ith (Check only		TOther (Speci	4.1
ion of	nding Phy ath. r: After this e funeral d	atlon; To	27. Manner of Death Natural 5 Pending Accident investigs	28a. Date of (Month,		28b. Time of Injury	f 28c. In	njury at Vork?		28d. Describe			(y)
Divis	s after des s Director	Certification;	3 Suicide 6 Could not determine	28e. Place of building	Injury - At he , etc. (Specif	ome, farm, str	eet, factory, office	D9			Street and I wn, State)	Number or Rur	al Route Number,
	To the Hospitel or Attending Physicien: within 42 hours after death. To the Furneral Director. After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the bas and manner	s of examina	owledge, death tion and/or in	n occurred at the vestigation, in m	time, dat y opinion,	e and place death occu	e, and due to the	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	1-D -				ense numl		71		signed (Month,	Day, Year) 2007 ·
	1 .1		14.12	` '			<i>y</i> .		ノフン	7	(2		2/221

	1 - State Registrar			Ce	rtificate of	Death		Reg	g. No.2 () ()7	39916
ĭ	1. Decedent's Name (First, Middle,	, Last)						ate of Death		Year	3. Time of Death
ian cal	GLENN PAUL KASUBIN	ISK I						Dec	62	007	0951
ner	4a. Facility Name (If not institution,	, give street and nu	mber)		4b. City, Town,		Death		4c. County of		
	5. Social Security Number	6. Sex	7. Age (In yrs. lasi	t birthday)	GLEN BU If Under 1 Year	If Under 24	4 Hrs. 8. D	ate of Birth	ANNE AR	9. Birthplac	ce (State or Foreign
	220.56.0982	1 □ M 2 □ F XX	57	Yrs.	Months Days	Hours		Month, Day, 1 B 1, 19		Country, ₩	*
	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	ocation					10d.	. Inside City Limits
ō	A. 2004.W	DUNDEL									1 □Yes 2 □No
Director	MD ANNE A 10e. Street and Number	KUNDEL	GLER	BURNI	10f. Zip Code			10	g. Citizen of Wh	hat Country	
Funeral Di	6029 LOCUST AVE				21061				τ	JSA	
5	11. Marital Status	12. Was Dec	edent Ever in U.S. orces?	13.	Was Decedent of If Yes, specify Cu	Hispanic Origi ban, Mexican,	in? (Specify ` Puerto Ricar	Yes or No- n, etc.)		- American	
	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, G	2 □ No ive XX		1 □ Yes XX No				Specify:		
ed by	15. Decedent	Year or D		16a. Dece	dent's Usual Occu	pation		1	6b. Kind of Bus	WHITE siness/Indus	stry
Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)		(Give	kind of work done DO NOT use retir	è durina most e	of working				
S	12	Joiloge (P	ROCESSOR				SOCIAL SE		ADMIN
Be (17. Father's Name (First, Middle, L	Last)							laiden Surname	?)	
P	ANDREW KASUBINSKI 19a. Informant's Name/Relationsh	-t- (T D-(-t)	-	40h 18aili	ng Address (Stree		Y YOUNG		City or Town 6	State Zin C	lada)
	KENNETH KASUBINSKI	, , , ,	SON		MOUNT VE						ouc,
	20a. Method of Disposition		20b. Plac	e of Dispo	osition (Name of matory or other pl	i	Date		20c. Location - C		n, State
	XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		CEMETERY	1	.11.200	7 G	LEN BURNI	IE, MD	
	21. Signatura if Funeral Service L	Licensee		_2	2. Name and Add	ress of Facility					
				11-1	NK FUNERAL	HOME, P	'.A.				
	K GREGORY FINA		M01148	42	2. Name and Addi NK FUNERAL 6 CRAIN HW	Y S. GLE	N BURNI				
	23a. Part Enter the Visease, or shoc or heart fail ite. Link		caused the death.	42 Do not en	6 CRAIN IN	Y S. GLE	N BURNI cardiac or res	piratory arre	st,	lr	Approximate nterval Between Onset and Death
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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM P. JONES, MD, DEPUTY 6131 SHADY SIDE RD. SHADY SIDE, MD 20764

31. Date filed (Month, Day, Year)

DEC 1 3 2007

07-09511 Kristen Lippy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 39917

	1- For State Certificate of Death								Reg.	No.		, , , , , , , , , , , , , , , , , , , ,
Physicia	an/	 Decedent's Name (First, Middle 							ate of Death	_		3. Time of Death
edical Exami	ner	Kristen Anne Li						De	onth ecember 8	Day Yea 3, 2007		0847 hrs
		4a. Facility Name (if not institution		umber)	4	b. City, Town, or Lo	ocation of De	eath		4c. County of	of Death	
		1900 Somerworth St.				Baltimore				r	ı/a	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year			Date of Birth	(MM/DD/YYYY	9. Birth Foreign	place (State or
Director		5. Social Security Number 21.7-25-4764 @!& @% \$&#\$</th><th>1 M 2 X F</th><th>18</th><th>Yrs.</th><th>Months Days</th><th>Hours</th><th>Min. 8</th><th>3-28-1</th><th>989</th><th>Cour</th><th></th></tr><tr><th></th><th></th><th>Usual Residence of Decedent</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tr><tr><th>/ any</th><th></th><th>10a. State 10b. County</th><th></th><th>10c. City, 1</th><th>Town or Location</th><th>on</th><th></th><th></th><th></th><th></th><th></th><th>10d. Inside City Limits</th></tr><tr><th>nd show</th><th>卢</th><th>Maryland n/a</th><th>ı</th><th></th><th>Baltin</th><th>nore</th><th></th><th></th><th></th><th></th><th></th><th>1 Yes 2 No</th></tr><tr><th>Maryland 28a-f show</th><th>Director</th><th>10e. Street and Number</th><th></th><th></th><th></th><th>10f. Zip Code</th><th></th><th></th><th>10g</th><th>ry?</th></tr><tr><th>th the Maryland 23a or 28a-f sho</th><th>Ë</th><th>1900 Somerwort</th><th>h Street</th><th></th><th></th><th>21</th><th>.230</th><th></th><th colspan=3>10g. Citizen of What Country? United States</th><th>28</th></tr><tr><th>with 1 s 23s</th><th></th><th>11. Marital Status</th><th></th><th>cedent Ever in U.S</th><th>5. 13. Was</th><th>Decedent of Hispa</th><th></th><th>(Specify</th><th></th><th></th><th></th><th>an Indian, Black,</th></tr><tr><th>eath item</th><th>Funeral</th><th>1 X Never Married 2 M</th><th>arried Armed F</th><th>orces?</th><th></th><th>es, specify Cuban, I</th><th></th><th></th><th></th><th>White</th><th>e, etc.</th><th></th></tr><tr><th>fler d</th><th></th><th>3 Widowed 4 Div</th><th colspan=4>wed 4 Divorced If Yes, Give Year or Dates:</th><th>specify:</th><th></th><th></th><th>Specify:</th><th>Whi</th><th>.te</th></tr><tr><th>hours af "natural</th><th>d by</th><th>15. Decedent's Education (Spe</th><th colspan=4>ent's Education (Specify only highest grade completed) 16a. De</th><th>n (Give kind</th><th></th><th>ione 1</th><th>6b. Kind of Bu</th><th>siness/In</th><th>idustry</th></tr><tr><th>72 hc</th><th>ete</th><th>Elementary/Secondary (0-12)</th><th>College (</th><th>during mo</th><th>st of working life. [</th><th>OO NOT use</th><th>e retired)</th><th></th><th></th><th></th><th>1-1</th></tr><tr><th>036 ithin 7, ne. r than</th><th>d</th><th>10 years</th><th colspan=5>) years n/a</th><th></th><th> </th><th>Restau</th><th>ırant</th><th></th></tr><tr><th>5-003 led within tygiene. other th</th><th>Completed</th><th>17. Father's Name (First, Middle,</th><th>Last)</th><th></th><th></th><th>Vaitress</th><th>3.Mother's N</th><th>lame (Firs</th><th>t, Middle, Ma</th><th>iden Surname</th><th></th><th></th></tr><tr><th>21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica</th><th>Be</th><th>John Lippy</th><th colspan=5>John Lippy</th><th>Mart</th><th>in</th><th></th><th></th><th></th></tr><tr><th>ID 21215-003 should be filed within and Mental Hygiene. This marked other the natic event, the Med</th><th>ဥ</th><th></th><th colspan=5>. Informant's Name/Relationship (Type, Print)</th><th></th><th></th><th>er, City or Tow</th><th></th><th>· · ·</th></tr><tr><th>MD 42 sh 1th an 1th an 1uma</th><th></th><th>Susan M. Lippy</th><th></th><th>Conway S</th><th></th><th></th><th></th><th></th><th></th><th></th></tr><tr><th>Ore, MD 21215-0036 es 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than 'her traumatic event, the Medical</th><th></th><th>20a. Method of Disposition</th><th>2 D</th><th>lace of Disposi ematory or oth</th><th>tion (Name of ceme er place)</th><th>etery,</th><th>Dat</th><th>е</th><th>20c. Location -</th><th>City or 7</th><th>own, State</th></tr><tr><th>Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once</th><th></th><th>1 X Burial 2 Cremation 4 Dopation 5 Other St</th><th></th><th>TOTA CIERC</th><th>-</th><th>. Cemeter</th><th>v 12</th><th>2-12-</th><th>.2007 1</th><th>3rook1v</th><th>n Po</th><th>rk MD</th></tr><tr><th>altir nit. I artme sortar</th><th></th><th>21. Signature of Funeral Service</th><th>Licensee</th><th></th><th>22 N</th><th>ame and Address o</th><th>of Facility</th><th></th><th></th><th></th><th></th><th>110, 110</th></tr><tr><th>Dep Training</th><th></th><th></th><th>J. Wayne</th><th>Osterlin</th><th>, Mc(</th><th>ully-Pol E. Fort</th><th>yniak</th><th>Fune</th><th>eral Ho</th><th>ome, Pi</th><th>\$30</th><th></th></tr><tr><th>Physician</th><th><</th><th>23a. Part I. Ent the sease, or</th><th>complications that of</th><th></th><th>Do not enter th</th><th>e mode of dying, s</th><th>uch as cardi</th><th>iac or resp</th><th>piratory arres</th><th>t, shock, or he</th><th>art</th><th>Approximate Interval</th></tr><tr><th>/Medical</th><th></th><th>failure. List only one cause</th><th></th><th></th><th>5529800</th><th></th><th></th><th></th><th></th><th></th><th></th><th>Between Onset and Death</th></tr><tr><th>Examiner</th><th></th><th>or condition resulting in death)</th><th>Due to (or as</th><th>ic intoxica a consequence of)</th><th>tacn</th><th></th><th></th><th></th><th></th><th></th><th>-</th><th></th></tr><tr><th></th><th></th><th>Sequentially list conditions,</th><th>b</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tr><tr><th></th><th>Examiner</th><th>if any, leading to immediate cause. Enter Underlying Cause</th><th>Due to (or as</th><th>a consequence of)</th><th>:</th><th></th><th></th><th></th><th></th><th colspan=3></th></tr><tr><th></th><th>a</th><th>(Disease or injury that initiated events resulting in death) Last</th><th>C</th><th>a consequence of)</th><th>:</th><th></th><th>_</th><th></th><th colspan=3></th><th>1</th></tr><tr><th>ansit d</th><th></th><td>events resulting in death). Last</td><td>d.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><th>Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial - transi</th><th>sician/Medical</th><th>X UNPENDED</th><th>X AMENDED</th><th>5 per f</th><th>h_g874</th><th>12-13-07 , perME,g8</th><th>vt .</th><th></th><th></th><th></th><th></th><th></th></tr><tr><th>8760, tificate being physicials the burians</th><th>Je J</th><th>IF FEMALE:</th><th></th><th>#25a.PIT</th><th>27,28a-f</th><th>, perME,g8</th><th>75, 1/1</th><th>5/08.7</th><th><u>T</u></th><th>23d. Date of</th><th>delivery</th><th>L</th></tr><tr><th>187 Hiffice Ing pl as th</th><th>2</th><th>23b. Was decedent pregnant in the past 12 months?</th><th>ne 1 Live</th><th>birth</th><th>₂ Fet</th><th>al death 3</th><th>Ectopic pre</th><th>egnancy</th><th></th><th>Month</th><th></th><th>ay Year</th></tr><tr><th>Box 68 e death certi the attendin ed for use as</th><th>ij</th><th>1 Yes 2 No 9 V Unit</th><th>4 Preg</th><th>nant at time of dea</th><th>th</th><th>ner (Specify)</th><th></th><th></th><th></th><th></th><th></th><th></th></tr><tr><th>BC le dea</th><th>Phys</th><th></th><th>9 Unkn</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tr><tr><th>P.O. s that the gned by e detach</th><th>by P</th><th>Part II. 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Was case referred to medica</td><td>П</td><td></td><td></td><td>26.Place o</td><td>of Death (Ch</td><td>neck only o</td><td></td><td></td><td>V Te.</td><td>, 2 10</td></tr><tr><th>Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should to</th><th>o Be</th><th>examiner?</th><th>Heenitel:</th><th>Inpatient 2</th><th>ER/Outpatient</th><th></th><th>Mh n n .</th><th>lursing Ho</th><th></th><th>esidence 6</th><th>✓ Other:</th><th>Scene</th></tr><tr><th>of \ g Phy her th</th><th>⊢†</th><th>1 ✓ Yes 2 No 27. Manner of Death</th><th></th><th></th><th>28b. 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Name and address of person who completed cause of death (Item 23a) Margarita Korell MD Assistant Medical Examiner 111 Pe</th><th colspan=5>11 Penn Street, Baltimore, MD 21201</th></tr><tr><th></th><th></th><th colspan=5></th><th></th><th>١٧١ ٢ ١٧١</th><th>-</th><th></th><th></th><th></th></tr><tr><th>St Regist</th><th>ate :rar</th><th>31. Date filed (Month, per Car)</th><th>1 3 2007 32. R</th><th>Salar Solgifatur</th><th colspan=5>Le Sharks</th><th></th></tr><tr><th></th><th>_</th><th></th><th></th><th>25.3</th><th>and the second</th><th></th><th></th><th></th><th></th><th></th><th></th></tr></tbody></table>										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2307 Olive Mellen ecember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himor atousv 0 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec . 17 Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 92 272-07-1832 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Glen Burnie 1 Yes 2 No la or 28a-f sh t be notified MD Anne Arundel Director 10g. Citizen of What Country? United States 10e. Street and Number 144 Alview Terrace 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n once. 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Completed by Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Legal Industry Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver Koehr Ruth Chandler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Alview Terrace, Glen Burnie, MD 21060 Tess Ketteringham, Daughter in Law 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory 12-11-2007 Odenton, MD 22. Name and Address of FacilityAmbrose Funeral Home, Inc. Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient မှ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 Accident death. Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Malde

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** December 8. 200 Ruby Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laure rince If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun. 1, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Days Hours Illinois 1 □ M 2 🕅 F Yrs. unknown Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Oaklawn TT. Director Prince George's Laurel 10g. Citizen of What Country?
United States 10e. Street and Number 7005 West 87th Street 10f. Zip Code 60453 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married or i Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: White Specify: δ "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home N/A Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ristick Ruby Ristick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7005 West 87th Street Oaklawn, Ill. 604 19a. Informant's Name/Relationship (Type. Print) Peter Lee, brother 60453 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition

1 □ Burial 2 □ Cremation Date 20c. Location - City or Town, State 3X Removal from State 4 □ Donation 5 ☐ Other (Specify) uneral Home 12-10-2007 Oaklawn, Illinois 22. Name and Address of Facility Ambrose Funeral Flome, Inc. 12-10-2007 Funeral Home - Anarer 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1_Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vesta

3001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend #5 PerFH G874 12/13/27 the Reg. No.

Reg. No. Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1635 MARKS DECEMBER 2007 TREDERICK 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BATVIRW CENTER BISTIMORE BALLMORE MALYLAND CITY HOPFIUS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. July 30, 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex S2113=30-10352 **Funeral** Months Days 1 📈 2 🗆 F Maryland 74 Director Usual Residence of Decedent 10d. Inside City Limits iled within 72 hours after death with the Maryland 10c, City, Town or Location 10b. County 10a. State 'natural', or items 23a or 28a-f show dical Examiner must be notif<u>ied at</u> 1 □Yes 2 □No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 800 Cedar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Distillery Mechanic 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 Is marked oth Be Anna Carolina Green John Thomas Marks မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 800 Cedar Road, Essex, Maryland 21221 wife Mary Lou Marks 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 14, 2007 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 120171 Physician INSUT ADDIVINAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 120.441 BOWKE PRAGUATION Sequentially list conditions, it as a least the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 20 0145 be executed burial-transit INFLORED ADRICE ASSESSION Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHEONIC OBJECTIVE Puinsonny PISZASZ peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an enovery page 2 s autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No spital or Attending Physhours after death.
Ineral Director; After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, DEC

PAILDINE

Day, Year) 2007

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MO

Registrar DHMH 17 Rev 1/2001

State

29c. License number

D44849

blins Holler BAYVIEW MUILAR CENTER BALTIMONE MARYLAND

29d. Date signed (Month, Day, Year)

DECEMBER 10 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydienes O. O. 7

		-	For State Registrar	te of Maryland /	-	tment of Heificate of L		itai Hygie Reg	6001	39921
	Physicia	an	1. Decedent's Name (First, Middle, Last)				_	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	<u></u>	igar				cember	11, 2007 4c. County of Deat	6:05 pm ^M
	Examin	er	4a. Facility Name (If not institution, give street a Edenuald	nd number)		4b. City, Town, or Towsc			Baltimo	
	Funeral		5, Social Security Number 6. Sex	7. Age (In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hrs p	Date of Birth		hplace (State or Foreign untry)
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	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loca	ation				10d. Inside City Limits
	fanyla shov	5				20011				1 ☐ Yes 2 ☐ No
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	ems 2	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces?	13. W	as Decedent of His	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	14. Race - Ame Black, Whit	
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Maryland 21215-0036		edt	15. Decedent's Education		Sa. Decede	nt's Usual Occupa	tion	16	b. Kind of Business	
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7	should ind Men i marka umatic	2	Michael Magar 19a. Informant's Name/Relationship (Type, Pri	(at) 19	9h Mailing	Address (Street a	nd Number or Rural R			Zip Code)
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ē,	s 1 and 3 f Health itam 27 other tr		20a. Method of Disposition	20b. Place	of Disposi	ition (Name of atory or other place		20	c. Location - City or	Town, State
m	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)				em. 12/15/C	17 և	Joodlawn,	Maryland
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or other tr. once.		21. Signature of Funeral Service Licenses			Name and Addres				ork Road
	₹ □ = 6 0		23a, Part1. Enter the disease or complication	that agueed the death. De	Ruc	the made of duing	r Funeral H	IOME, IT	nc. Towsor	1, Md . 21 204 Approximate
	A CONTRACTOR OF THE PARTY OF TH		23a. Part1. Enter the disease or complication shock, or heart failure. List only the caulimmediate Cause (Final	se on each line.	7.	(iii) iiiode or dying	(m)	1.0 mp	•	Interval Between Onset and Death
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de.	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Que to (or as a consequent	211	VIL >	ryash	me		2905
2,09289	Attanding Physician: The law requires that the death certificate be executed reach. Geath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	ai E		oue to (or as a consequence	26 01).		•			,
687	ficate physis the	edicai	d							
Box	eath certi attending for use a		IF FEMALE: 23c. If y	es, outcome of pregnancy	ath 3∏£	Ectopic pregnancy			23d. Date of de	•
. B	w requires that the death cer been signed by the attendir should be detached for use	by Physician/M	1 Yes 2 No	Pregnant at time of death Unknown		Other (specify)			Month	Day Year
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Division of Vital Records, P.O.	signe d be c	d by	Part II. Other algument conditions continue	ng to doubt out not resulting	g iii alo ali	adity ing daddo give		1 🗆 Yes		robably 4 Unknown
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Re	sician: The lav certificate has rector, page 2	d Ho						autopsy performe 1 ☐ Yes 2	ed? death?	completion of cause of 2 ☐ No
ta	an: Trifical	Be C	25. Was case referred to medical				26. Place of Death (C		9	
>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2 ☐ No Hospita	I: 1 Inpatient 2 ER/0	Outpatient	3□ DOA Othe	4 Nursing Home		ce 6 □Other (Spe	cify)
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isic	Attandi death. ctor: A y the ft	icat	3 ☐ Suicide 6 ☐ Could not be 39	. Place of Injury - At home,	. farm. stre			Location (Stre	et and Number or R	ural Route Number,
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	To the Hospital or Attanding Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Examiner: 0	To the best of my knowled n the basis of examination	dge, death and/or inve	occurred at the timestigation, in my or	ne, date and place, and pinion, death occurred	due to the cau at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	thin 24 thin 24 tha F mplete	Medicai	29b. Signature and title of certifier	nd manner stated.		29c. License			d. Date signed (Mon	
	Z × Z			a 6/					12/12	107
			30. Name and address of person who complet	ed cause of death (Item 23a	a) (Type, P	Print)	b //.	01	0 11 2	1 4 222
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		1 - For State Registrar	State of	Marylan		artment				_	giene	007	39922
	-	Decedent's Name (First, Middle, L.)	ast)							2. Date of De	ath		3. Time of Death
Physic /Med		Gladys E. McQua	de							Dec.	9	Year 2007	8:31 P M
Exam		4a. Facility Name (If not institution, g		4b. City, 7	Fown, or	Location of	of Death		4c. (4c. County of Death			
	GBMC						Towson					Baltimore	
Funera		,	Sex 1 □ M 2 □ F	7. Age (In yrs. 88	last birthday) Yrs.	Months	ths Days Hours Min. 8. Date of Birth (Month, Day, Yer Aug. 3 19					Co	thplace (State or Foreign buntry)
Directo		215-07-5847 Usual Residence of Decedent	21.	00						Aug. 3	171	y File	,
yland 10W		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
e-fsl	ctor	MD Baltimo	re		Cock	eysvi	11e						1 ☐ Yes 2 ☐ No
or 28	Director	10e, Street and Number				10f. Zip		000			10g. Citiz	en of What Co	ountry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23a or 28e-f show ent, the Medical Ever it wermant be coulded at	6	505 Warren Rd.	1.0.111		2 40			030	-:-2 (0	-it. Van av Na	1.	USA 4. Race - Ame	orioan Indian
er de Items	Funeral	Marital Status Never Married 2 Married	Armed For		.S. 13.	Was Deced If Yes, spec	ent of Hi rfy Cuba	n, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)	- '	Black, Whi	
J36	by F	3 Widowed 4 □ Divorced	1 □Yes If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2	X No	Specify:				Specify: W	nite
5-0C	ted	15. Decedent's	Education		16a. Dece	dent's Usua	l Occupa	ation	t of working	10	16b. Kir	nd of Business	/Industry
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and be fil ntal H od oth	Be	17. Father's Name (First, Middle, Lat	st)							(First, Middle, Lide Tu		Sumame)	
hould d Mer mark mark	ို	William Burgess 19a. Informant's Name/Relationship	(Type Print)		19h Mailir	na Address	(Street a					Town, State,	Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Ever it infilinist be recitified at		Andrea Gillespi		ev		•						D 21204	
F. F. F. F. F. F. F. F. F. F. F. F. F. F		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crei	sition /Nam	ne of		, D	ate		cation - City or	
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m ades	Ž.	Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093											
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that c ly one cause on e	aused the deat ach line.	h. Do not ent	ter the mode	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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/Medica Examine		resulting in death)	Due to (or as a consec	uence of):			il.	- 10	0.1			1006
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rtifica		IF FEMALE:											
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P.O. Box nat the death cert dby the attendin etached for use	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	ant at time of o	leath 5L	Other (sp	ecify)						
S, P.O. BOX 6: res that the death certific igned by the attending p be detached for use as	H.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did t	obacco u	se contribute t	o the cause of death?			
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ng Pł		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Moni	of Injury th, Day Year)	28b. Time o Injury		8c. Injur Wor			28d. Describe	how injur	y occurred	
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Di To the Hospitel or Within 24 hours afte To the Funerel Dir completely filled in		29a. Certifier 1 Certifying	Physician: To the	best of my kn	owledge, deat	h occurred	at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner a	s stated.
ie Hoo n 24 h te Fui	Medical	(Check only 2 Medical Ex	aminer: On the b	asis of examina ner stated.	ation and/or in	vestigation,	in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and du	e to the cause(s)
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	1	·) AT	TENDY	16 M	0	00	0 2	.55	38	12	101	0 ナ
9,		30. Name and address of person wh	no completed caus	e of death (Ite	m 23a) (Type,	Print)							
\		Peter P. Stama 31. Date filed (Month, Day, Year)	s, M.D.	tegistrar's Sign	3320 Be	LLona	Ave	e., S	uite	120, B	alto	., MD	
Regis	itate strar	31. Date filed (Month, Day, Year) DEC 1 3 2	007	isso de	S SIGN	encis							

		For State of State of Registrar		artment of Hea rtificate of De	Ith and Mental Hyg ath	giene _{Reg. No.} 2007 3992.			
. Physic /Medi	cal	Decedent's Name (First, Middle, Last) JOSEPH AVON 4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Loc	2, Date of De Month Decembe	ath 3. Time of Death Day Year			
Examii Funeral Director	c	JOSEPH RICHIE HOSPICE	Age (In yrs. last birthday,	BALTIMOI		N/A th y, Year) 9. Birthplace (State or Foreign Country)			
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND N/A 10e. Street and Number 1105 GREENMOUNT AVENUE 11. Marital Status 1 Never Married 2 Married 3 Widowed XXDivorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown 17. Father's Name (First, Middle, Last) JAMES NICKENS 19a. Informant's Name/Relationship (Type. Print)	ant Ever in U.S. as? 13. May be st. 16a. Dece (Give life. COM)	BALTIMORI 10f. Zip Code 21202 Was Decedent of Hispau If Yes, specify Cuban, N 1 Yes 2KM o Sp edent's Usual Occupation a kind of work done durin DO NOT use retired) MUNITY ACTIV 18.	E 2 nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.) 2 2 3 3 4 7 Mother's Name (First, Middle, LUCILLE TURNE)	10d. Inside City Limits 1XXYes 2□No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry BALTIMORE CITY Maiden Surname)			
baitimore, Maryla permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		Sophie Turner/Companion 20a. Method of Disposition Burial 2XX remation 3 Removal from St. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ate 20b. Place of Disp cemetery, cre METRO CI	osition (Name of amatory or other place) REMATORY 2. Name and Address of NILLIAM C BH	Date 12/12/07 Facility ROWN COMMUNITY H AVENUE	more, Maryland 21202 20c. Location - City or Town, State BALTIMORE, MARYLAND FUNERAL HOME P.A.			
ificate be executed / Medical Examiner is bhysician and is the burial-transit	dical Examiner	Ecquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of): as a consequence of): as a consequence of):	arcino.	ma with	rrest, Approximate Interval Between onsylvand Death			
13, F.O. BOX 66/0U, res that the death certificate be exigned by the attending physician be detached for use as the buriar buriary.	Physician/Medica		h 2 ☐ Fetal death 3 nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
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To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	1 Yes 2 No rospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe							
To the Hospita within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Description** 2 **Description** 2 **Description** 3 **Description** 4 **Description** 2 **Description** 3 **Description** 4 **Description** 4 **Description** 5 **Description** 4 **Description** 5 **Description** 6 **Description** 1 **Description** 1 **Description** 1 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 1 **Description** 1 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 1 **Description** 1 **Description** 2 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 1 **Description** 2 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 1 **Description** 2 **Description** 2 **Description** 3 **Description** 4 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 1 **Description** 2 **Description** 2 **Description** 3 **Description** 4 **Description** 2 **Description** 3 **Description** 4 **Description** 2 **Description** 3 **Description** 4 **Description** 5 **Description** 5 **Description** 1 **Description** 2 **Description** 2 **Description** 3 **D							
St. Regist	ate rar	30. Name and address of person who completed cause 31. Date filed (Month, Day, Year) 32. Rec	of death (Item 23a) (Type	Pillerwood	Rd Both	1 Mil 2/2/8			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1)-2 (2 10, 2007 Henry C. Perkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner en 180 Baltimore-Washington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 2 M 2 □ F 90 460-64-1603 Texas Director Dec. 11, 1916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or USA 346 Bar Harbor Road 21122 "natural", or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed by 3 Widowed 4 ☐ Divorced r than "natur the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) lith and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) U. S. Navy 12 Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Perkins Calvert 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Perkins (son) 440 Old Mill Road, Millersville, Maryland 21108 Department of Health Important: If Item 27 any Injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 12/15/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugreral Service Licensee 22. Name and Address of Facility Machain Road, Pasadena, Maryland 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nmomo week **Physician** /Medical (or as a consequênce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con y quenc y of Examine he law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, p. ge 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe Yes 2 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ♣0 1 patient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

Reference After After Street After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tible of certific 30. Name and address of person who compl cause of death (Item 23a) (Type,

Registrar

OF

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PROPST DALE BERNARD 08 2007 DECEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vs. last birthday) Social Security Number **Funeral** 1**∑**M 2□F Months Hours 4-20-1934 Virginia Director 235-52-7414 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 X Yes 2 No Director Maryland n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 United States 802 E. Fort Ave. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magonee. College (1-4or 5+) Elementary/Secondary (0-12) 9 yéars n/a Supervisor Paper Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Bethel Propst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Propst (wife) 802 E. Fort Ave. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Pk. 12-13-2007 Glen Burnie, MD 21. Signature of Puneral Service Licensee McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, MD 21230 J. Wayne Osterling 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS

Due to (or as a consequence of): 4 WEEKS **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Atter ding Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: f yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth Month Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topecco use contribute to the cause of death? Completed by ARTERY DISEASE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CONFESTIVE HEART FAILURE 24a. Was an autopsy performed Yes 2 No CHRONZC 1□ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural Injury within 24 hours aren com.

To the Funeral Director. Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fo the Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SOSE VARGA

JOHNS HOFILING HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287

30. Name and address of poon who completed cause of death (Item 23a) (Type, Print)

RES-000

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla		artment <i>tificate</i>			Mental Hyg	giene Reg. No.	07	39926	
	Physici		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location ol Death 4c. County							2007	3. Time of Death 7:30 A M			
	/Medio Examin									h	4c. County of Death			
	Filmont		5. Social Security Number	6. Sex 7. Age (In yrs. last birthday)				Westminster If Under 1 Year If Under 24 Hrs. 8 Date 0			control Carroll of Birth 9. Birthplace (State or Foreign			
	Funeral Director		216-18-7598	1□M ¾ □F			Months Days Hours Min.		Dec. I	8. Date of Birth Month, Day Year, 1915		aryland		
	and T		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits	
:	a-f eh	tor	MD Ba	altimore			Bal	timor	e:				1 ☐ Yes 2 ZNo	
	Nor 28	Dire	10e. Street and Number				10f. Zip (Code			10g. Citizen o	of What Cour	ntry?	
	ns 23	erai	1259 Brewster		edent Ever in I	J.S. 13.1	Was Decede		227	Specify Yes or No-		ited S		
21215-0036	permit. Pages I and 2 should be liled within 72 hours after death with the Maryland Inportment of Health and Mential Hygiene. Importment if litem 27 is marked other then "natural", or items 23a or 28a-f ehow eny injury or other traumetic event, if a Medical Examinal must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F ned 1 ☐ Yes	orceey? 2 ∰ No ive	1	fYes, specif	fy Cuban,	Mexican, Puèr Specify:	to Rican, etc.)	Spec	lack, White,		
-2-1 15-0	"natu	letec	(Specify only highest grade completed) (Giv				edent's Usual Occupation e kind of work done during most of working				16b. Kind of	16b. Kind of Business/Industry		
212	r then	ошо	Elementary/Secondary (0-12)		DO NOT use retired) Homemaker				Own Home					
Maryland	rid be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Baranayai 18. Mother's Name (First, Middle, Maid Catherine Ma											
Mary	aith and h		19a, Informant's Name/Relations Mary Bokman -	hip <i>(Type, Print)</i> Daughter		19b. Mailir 1259	Brews	Street and	Number or Ri Street	, Baltimo	r, City or Tow Ore, M	m, State, Zip D 2122	Code)	
altimore,	ges 1 g it of He if item or othe	1	26a. Method of Disposition	3 □Removal from	1 N/I	Place of Dispo	sition (Name	e of ner place)	1 10	Date	20c. Location	n - City or To	own, State	
itim S	artmen ortant: injury		4 Donation 5 Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc.											
ñ	in or or or		Dellam !	JUL D	W/MO1:	J// 13	28 Su.	lphur	Spring	g Rd., Ai	butus	, MD 2	1227	
	hysician		23a. Part 1. Enter the disease, or shock, or heart lailure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the dea					-		are	Approximate Interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Attrocellerates Vascular Disease 259 Due to (or as a consequence of):											
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
Ö,	physicien and the burial-transit		that initiated events resulting in death) Last	c	(or as a conse	quence of):								
		edical		d										
.O. Box	the attending phenology for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1							23d. Date of delivery Month Day Year		,	
o. 3	as been signed by the a 2 should be detached f	by Ph							23e. Did to	tobacco use contribute to the cause of death?				
ords	been sign									1 🗆 Y	Yes 2 No 3 Probably 4 □Unknown			
E 3	ate h	Completed								24a. Was a autop perfor	sy	o. Were auto prior to con death? 1 \(\subseteq Yes	psy findings available mpletion of cause of	
Vita	certilic irector.	o Be	25. Was case referred to medical examiner?	Hospital:		7500		Other		ath Check only or	***			
0	ter this neral d	-	1 Yes 2 No 27. Manner ol Death	28a. Date		28b. Time of	1 3 DOA 4 Nursing Home 5			Y	5 Residence 6 Other (Specify) Describe how injury occurred			
Sior	ar deeth. ector: Alter by the funer	catio	1 Natural 5 Pendin 2 Accident investig	gation	nii, Day rear)	Injury								
	5 6 5 5	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, Iarm, stree building, etc. (Specify)					eet, factory, office 28J. Location. City or To			Street and Number or Rural Route Number, wn, State)			
3	within 24 hours a To the Funeral C	edical	29a. Certifier 1 Certifyin (Check only one) 1 Madical	ig Physician: To the Examiner: On the band man	e best of my kn casis of examin iner stated.	owledge, death ation and/or inv	occurred at estigation, i	t the time, n my opini	date and place ion, death occu	a, and due to the during at the time, of	ause(s) and r late and place	manner as si e, and due to	tated. the cause(s)	
, F	within To the	Me	29b. Signature and title of certified			24		License n			29d. Date sign		•	
•	,		1 Chym	won		tonm	0 7	02	544	3 /	2/10	1200	07	
	2		30. Name and ddress of person	who completed cau	177	m 23a) (Type,	Print)	6R	d. U	estous	mte	N	07 1 D 21157	
	Sta Registr		31. Date filed (Month, Day, Year)	32.4	Registrar's Sign	ature	sells		-1-1-1					

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** DECEMBER 9,2007 2:50 **JANIE** PAYNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. THOMAS MORE NURSING CENTER HYATTSVILLE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2X F Months Hours 577-30-4838 Director 93 02-11-1914 SOUTH CAROLINA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 27 is marked other then "naturel", or Items 23a or 28a-f ahow traumatic event, the Middigal Examinar must be notified at 1X Yes 2 □ No Director HYATTSVILLE PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4922 LASALLE ROAD 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify BLACK Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hygiene DOMESTIC PRIVATE 6 s 1 and 2 should be filed vil Health and Mental Hygie Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 ANDREW MITCHELL RENA LIGHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 215 10th STREET, NE WASHINGTON, DC 20002 VEOLA FRAZIER - NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if Ite
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State HARMONY MEMORIAL 12-15-07 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TAYLOR S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASHINGTON, DC 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner DECUBITUS SACRAL ULCER INFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit INFECTION TRACT URINARY Due to (or as a consequence of) ed by the ettending physician detached for use as the burial Physician/Medical ATRIAL FWITTER IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELITUS Completed peed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2X No certificete 1 Yes Hospital or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (Hospitelist) Dos Euple Kajal 64699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , TAKOMA PARL M.D. - 20912 7600 , CARROL AUSNUE 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar DEC 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Powell Sr. 8:30 P M Robert 2007 Bruce December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Genesis Eldercare- Heritage Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months Hours 1 XM 2 ☐ F December 31,1906 Pennsylvania 100 Director 218-07-1437 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 No Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or USA 21222 1508 Rita Road r death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married or. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: white þ 3 Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the Sales Insurance Company 12 years <u>4 years</u> n and Mental Hygiv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas S. Powell ပ Leka Davies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Robert Bruce Powell Jr. son 1508 Rita Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 13, 2007 21. Son ture of Fune al Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TIDA /Medical Due to (or as a consequence of): Examiner Sequentially list continioris, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ICTNE PULMONRY DISEATE burial-transit and Division or Vital Records, P.O. Box 68760 nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mapher of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 ☐ Pending investigation 1∏Yes 2∏No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28f. determined 4 🗌 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

use of death (Item 23a) (Type, Print)

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Place Drendake MD 2/222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year 9:45 A. Marshall H. Pinnix 80 2007 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/12/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Days Year) Months Hours 1√5 M 2 □ F 80 245-26-6475 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Baltimore 1 □ Yes 2 □ No Baltimore 10f. Zin Code 10g. Citizen of What Country? United States 10e. Street and Number 21212 724 Regester Avenue of America 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married ※ Married 2 No 1 ☐ Yes 🎗 🖾 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) finance security analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marshall Henry Pinnix Katherine Page 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valerie Spencer/daughter 8746 Gerst Avenue Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Date 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 13, 2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMATOMA SUSDULAL DAYS disease or condition resulting in death) Due to (or as a consequence of): FALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 No 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner and

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after a and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division or Vital

certificate be

Examine Physician/Medical þ Completed Be

use as the burial-tran attending physician for use as the buria signed by the a been page 2 has this certificate 2 funeral Certification: After spital or Attendi ours after death. neral Director: A death.

IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Tyes 2 TNo

27. Manner of Death

1 Natural

Accident

3 ☐ Suicide

(Check only one)

29b. Signature and title of certifier

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) No. 1900 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of Injury NKNONN M UNKNOWN

28c. Injury at Work? 1 ☐ Yes 2 X No

UMENINN

28f. Location (Street and Number or Rural Route Number, City or Town, State) AVE, BALTIMORE MD

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide HOME 29a. Certifier

724 Register fc Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brisan MA

29d. Date signed (Month, Day, Year) December 11 2007

State Registrar

Medical

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation



ORIGINAL

To the Hospital within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 2007 5:45 A^M Alice Lee Reca 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year) July 31, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months 1□ M 🎝 F Virginia 82 Yrs 230-26-3829 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Baltimore Gwynn Oak Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 2600 West Park Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Union Organizer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Napier Ernest Holzbach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Parkvue Road Fallston, Maryland 21047 Timothy Reca, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/17/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee MacNabb Funeral Home, P.A. Inomas Gregor 301 Frederick Road Cátonsville, Maryland 21228 Approximate Interval Between Onset and Peath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition weeks

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

5:45 A.M

Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Examiner

State

Registrar

Records, P.O. Box 68760.

Division or Vital

RECA

ALICE

2007 6

DECEMBER

The law requires that the death certificate be executed completely filled in by the funeral director, page 2 should To the Hospital or Attending Physician:

	resulting in death)	Due to (or as a conseq	uence of):				
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	uence of):				
dical Exa	resulting in death) Last						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2⊠ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 □Ectopic		23d. Date of de Month	vilivery Day Year	
P.	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ed b					1 ☐ Ye	s 25√No 3□P	robably 4 Unknown
Complet					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?				ath <i>(Check</i> on <i>ly</i> one)	
2	1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	, Laroning I	lome 5 ☐ Resider	nce 6 □Other (Spe	ecify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, str <i>e</i> et, fact fy)	28f. Location (Str. City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certification:		use(s) and manner a ite and place, and du					
Me	29b. Signature and title of certifier	e Wrigh	f MO	O 29	29d. Date signed (Month, Day, Year) December (Ith 200)		

VALLEY ROAD TIMONIUM, MD 21093

2300 DULANEY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Segistrar's Signature

ERNESTINE WRIGHT

DEC 1 3 2007

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sanders December 2007 Margaret /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 196 Oak Drive 8. Date of Birth (Month, Day, Jan 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Year 1 □ M 2 K F Days Hours Maryland 1936 71 215-32-3406 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 1 □ Yes 2 □ No r 28a-f sh Anne Arundel Pasadena Director Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be U.S.A. 21122 196 Oak Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical Hygiene. other than " ent, the Med College (1-4or 5+) N/A Elementary/Secondary (0-12) Own Home Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental F Elizabeth Murk Schro11 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 196 Oak Drive Pasadena, Maryland 21122 David R. Sanders (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 Crownsville, Maryland Crownsville V.A. Cem. 12/14/07 injury (4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Euneral Service Licenses 'n Approximate Interval Between Onset and Death 23a. Post. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause ρn each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as for use IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA 1 Inpatient ို 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 ☐ Pending investigation Injury Natural 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 and address of person who completed cause of death (Item 23a) (Type 0 2106

Registrar

State

31. Date filed (Month, Day, DEC 1

Year)

3 2007

2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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			_ State	ate of Maryland		artment of H <i>rtificate of L</i>				711111	39933
	x		Registrar 1. Decedent's Name (First, Middle, Last)			Timeate of L		2. Date of De	Reg. No.		3. Time of Death
	Physicia	_	Edna M. Smith					Month	1 Day	-10 Year	7 Z:30PM
	/Medic	4.0	4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of Death	Decen		County of Death	
	LAGIIII	C.	Charles	town			atons	Ville		Bat.	Limore
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av. Year)	Cor	oplace (State or Foreign
	Director		211-20-4236	94	Yrs.	lionale Baye		June 1	3, 1	913 Pen	nsylvania
	w .		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Maryl f sho ied a	ō	Maryland Baltimore	C	atonsv	71110					1 □Yes 2 🖾 No
	the 28a-	Director	10e. Street and Number		a cons v	10f. Zip Code		I	10g. Citi	izen of What Co	untry?
	h with	al D	709 Maiden Choic	e Lane		21228			U	SA	
	ems a	Funeral		Vas Decedent Ever in U.S	6. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White	
õ	after or ite		1 ☐ Never Married 2 ☐ Married	∏Yes 2∏No fYes, Give		1 ☐ Yes 21X No	Specify:	. ,		Specify: Wh	
9500-612	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	d by		ear or Dates:	162 Doco	dent's Usual Occup	ation		I 16h Ki	ind of Business/l	
고 다	n 72 "nat edic	Completed	15. Decedent's Education (Specify only highest grade continue)	mpleted)	(Give	kind of work done of DO NOT use retired	during most of work)	ing	TOD. KI	ind of business/i	lindustry
7	withi iene. • than the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		lc Teacher			Pub	lic Hea	1th School
0	il Hyg other rent,	a l	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden	Surname)	
/land	uld be Wenta Wenta rrked	To B	Leonard Mills				Lugenia	Rutled	lge		
Mar	2 sho and 1 Is ma auma	ľ	19a. Informant's Name/Relationship (Type.			ng Address (Street a				, ,	(ip Code)
	and sealth 71 27 ner tr	1	George M. Smith - S		1	Wilmett					
saltimore,	ges 1 If Itel or otl		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Remo	val from State	emetery, cre	osition (Name of matory or other place	1	Date		ocation - City or	
	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specify)	Met	ro Cr	ematory	12-12	2-2007	Cator	nsville,	Maryland
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licencee	2///	4	2. Name and Addres	ome of Ca	tonsvi	lle,	Inc.	ib witzke
		Н	23a. Part1. Enter the disease, or complication	ons that caused the death		1630 Edmo: ter the mode of dyin				sville,	Approximate
	Physician		shock, or heart failure. List only one commediate Cause (Final	ause on each line.		. 1 :					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	NTIQ.					
	Examiner		h h								
N.	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Error Underlying	Due to (or as a consequ	ence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	anna of):						
8/60,	icate be executed physician and s the burial-transit	at Ey		Due to (or as a consequ	ence or _j .						
28	icate phys s the	dical	d								
ROX	the death certific y the attending p iched for use as	M/u		f yes, outcome pf pregna		Ci:				23d. Date of del	ivery
ň	death e atte	Physician/M	in the past 12 months?	1□Live birth 2□Fetal 4□Pregnant at time of de		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,			Month	Day Year
л Э		hys	9 🗆 Unknown	9□Unknown							
	es tha	by F	Part II. Other significant conditions contrib	uting to death but not resu	Iting in the u	underlying cause give	en in Part I.				the cause of death?
or o	requir sen si nould							10	Yes 2	∐No 3∐Pr	obably 4 Onknown
Hecords,	The law requires that ite has been signed b age 2 should be deta	Completed						24a. Was	psv	prior to	topsy findings available completion of cause of
<u></u>								1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2□No
VITAI	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	ital:		at 20 pgs Oth	26. Place of Deat				
ō	ding Phys I. After this funeral di	- L	I les 2 440	8a. Date of Injury	28b. Time o	III 3 DOA	4 Hoursing Ho	ome 5 ☐ Res 28d. Describe		6 ☐Other (Specify occurred	cify)
on	nding th. : Afte fune	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No		•	,	
UIVISION	Atter	ifica	a Could not be	8e. Place of injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location	(Street ar	nd Number or Ru	ural Route Number,
Ē	tal or 's afte al Dir ed in	Certification:	T I I I I I I I I I I I I I I I I I I I	Danding, etc. (opean)	/			Ony of 10		-/	
	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of		(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinat							
	thin 2 the o	Medical	29b. Signature and title of certifier.	and manner stated.		29c. Licens	e number		29d. Da	te signed (Mont	h. Day, Year)
	7 ¥ € 8		200. Signature and into one in the	Mr		0	117000	,	Do	1031	- 11 7007
	^		30-Name and address of person who compl	eted cause of death (Item	23a) (Tvne	Print)	OVJF		DE	CEMBA	11,0007
	7		Shame and abdress of person who comp	7/1 M	aido	u Chaic	eLano	Ba	17im	ove M	DZIZZB
	Sta		31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ture	1 N.			<u>`</u>		h, Day, Year) - 11, 2007 DZIZZS
	Registi	rar	DEC 1 3 2007	parties 1	S' A	TREEL S					

Please Type or Print in Black indensity 207 vt. amend item 1 per doc 8874 12-13-07 vt. State of Maryland / Bepartment of Health and Mental Hygiene

Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Katharine E. Smith 5 Katherine E. Smith Dec. 2007 11:14 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Keswick Multi Care Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country) NJ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 □ F Director 136-18-7841 1921 86 April Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland patith and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD n/a Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 40th St. 21211 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: ģ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Library <u>Librarian</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Haiback Katharine Schilling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4544 Ambermill Rd., Baltimore, MD 21236 Nancy L. Schkloven/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/8/07 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, 4 Donation 5 Other (Specify) MD 21093 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) peripheral VASCULAY **Physician** /Medical Due to (or as a consequence of): **Examiner** MELLITUS TUP II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLARUN ATMAL 1 Yes 2 No 3 Probably 4 HUnknown Crohn's Culi h5 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35102 On MO Munuly DECEMBER 6. 2007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 10 5901 North CHARLES Street BAILMON MANIANT DON M.D 31. Date filed (Month, Day, Year) 3 gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar Stumpf

4b. City, Town, or Location of Death

Joseph

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

John

3. Time of Death

5:35A^M

Date of Death
 Month

Month Day Year December 9, 2007

4c. County of Death

Physician

/Medical

			1232 Perry Cor	ner Road			Grason				Queen	Anne '	
it.	Funeral		5. Social Security Number	6. Sex 7. Age 1 X M 2 ☐ F		ast birthday)	If Under 1 Yea Months Day		Min. (Mo	e of Birth onth, Day,		9. Birthplac	ce (State or Foreign
	Director		220-14-1068	12X W 2	82	Yrs.			Jan	. 10,	1925		MD
	and w		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Lo	cation					10d	I. Inside City Limits
	fanyl f sho ed al	ō	MD Oueen	Anne's		Ca	asonvil	1.					1 ∐Yes 2∭No
	the 1 28a- notifi	Director	10e. Street and Number	Allife 5	1	GI	10f. Zip Code			10	Og. Citizen of V	What Country	/?
	3a or		1232 Perry Corn	ner Road			21638			1	U.S.A.		
	ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13.		Hispanic Or	igin? (Specify Yen, Puerto Rican,	s or No-		e - American	
٥	after or Ite		1 ☐ Never Married 2 🏹 Mar	Armed Forces? rried 1 MYes 2 □ N If Yes, Give	No		i Yes, specily Ci 1 □ Yes 2 🛣 N			eic.)		ck, White, etc y: Whit	
3	ours a ral", c Exar	by	3 Widowed 4 Divorced	Year or Dates:			TLL Tes ZIZIN	о ореспу.					<u> </u>
ה	72 h 'natu dical	etec	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during mos	st of working		16b. Kind of Bu		
9500-61212	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		oo nor use reti cker	red)		l	interna Longsho	reman'	s
	iled v dygie iher t nt, th		17. Father's Name (First, Middle	(ast)		Chec	KEL	18. Moth	er's Name <i>(First</i> ,	A	ssocia	tion_	
ä	be ital	Be							11e Sik			/	
Maryland	s 1 and 2 should be 1 f Health and Mental Item 27 Is marked o other traumatic eve	2	John A. Stumpf 19a. Informant's Name/Relations			19h Mailir	ng Address (Stre		er or Rural Rout			State. Zip C	Pode)
<u>B</u>	nd 2 saith an 27 is i		Mrs. Dorothy M		۵		-		Road Gr				
	st 1 and of Health Item 27	1	20a. Method of Disposition	· beampi/wire			sition (Name of natory or other p		Dec. 13		20c. Location -		
2	ages ent of t: If It		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (1	2007		Elkridg	o MD	
saitimore,	artme artme ortan injur	1	21. Signature of Funeral Service		riea		ge Mem. Name and Add		ty Single				mation
ğ	permit. Pages Department of H Important: If Ite any injury or of once.		1721	11/	Ma								D 21061
r			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused									Approximate nterval Between
	Physician		Immediate Cause (Final	t only one cause on each in	1 J	nelico	nna					1~	months Months
	/Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	71701						TYLOVETICS
	Examiner			. Dle	wo	90	ffus	ion					
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
Ç	an ar rial-t		resulting in death) Last	Due to (or as	a consequ	uence of):							
68/60 ,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		d									
	ing p	Mec	IF FEMALE:		,								
X Q Q	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregna				1	te of delivery onth D	/ Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	eath 5L	Other (specify)						
л Э	The law requires that the death, ate has been signed by the attenbage 2 should be detached for u	Ph	Part II. Other significant condit	tions contributing to death b	ut not resu	ulting in the u	nderlying cause	given in Part	I. 23				cause of death?
ďŠ,	signe signe	by		cancer		J	, 0			1 XYe	es 2 No	3 ☐ Probal	bly 4 □Unknown
Ö	w requir	Completed		tensio									100
ě	e law has b	ldu	nype	7411510	, ,					la. Was ar autops nerforn	V	prior to comp death?	sy findings available pletion of cause of
ита несог										perforn Yes 2		1 ☐ Yes 2	!□ No
=	Physician: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		ED/0. tti	- 0E DOA	Othor:	e of Death (Che				
o	Phys rthis ral di	- T	1 Yes 2 Mo 27. Manner of Death	28a. Date of Inju		28b. Time o	II JU DOA	4 LI N			ence 6 Oth ow injury occur		
0	ding h. After fune	tion	1 Matural 5 ☐ Pendi		y Year)	Injury		njuryat Vork? □Yes 2□			, ,		
UIVISION	Atten deat ctor: y the	fica	3 Suicide 6 Could	I not be 28e. Place of inju	ury - At ho	me, farm, st			28f. Lo	cation_(St	reet and Numi	ber or Rural	Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determ	building, et	c. (Specify	v)			Ci	ty or Town	n, State)		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this: completely filled in by the funeral director.			ing Physician: To the best									
	e Ho le Fu	Medical	(Check only 2 Medica one)	I Examiner: On the basis o and manner sta		tion and/or in	ivestigation, in m	iy opinion, de	eath occurred at t	he time, d	ate and place,	, and due to t	the cause(s)
	To the within To the Complex C	ž	29b. Signature and title of certifi	er (, ,		29c. Lice	ense number		25	9d. Date signe	ed (Month, D	ay, Year)
			1/ Marc	not X/M	lelo	Lio A	90 D	551	27		12/11	0/07	
	4		30. Name and address of pelso						1		1		
	U		Margaret D.Ma1				rive Sui	te E S	Stevensv	ille,	MD 21	666	
	Sta		31. Date filed (Month, Day, Year	r) 32. Registr			60						
	Registi		DEC 1 3 2	007 Reck	AR	Repair .							
DH	MH 17 Rev 1/2	UU1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorothea Alice Slawski 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Air Belair Health and Rehabilitation l'enter Del If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🔀 F Months Director Maryland 212-14-1652 Oct. 3, 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 1713 Ruger Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Health Care or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine (nmn) William Edward Cooke Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Walters Mill Road, Forest Hill, MD 21050 Terry Hite / Granddaughter permit. Pages 1 and Department of Healt Important: If item 2 any injury or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ဩBurial 2 □ Cremention 3 □ Removal from State Bel Air Memorial Gdns 12-15-07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Dyner (Specify) 21. Signature of Funer 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21909 ea h line. 23a Part1. Enter the disease, or complications to a shock, or heart failure. List only one cause of Do not enter the mode of dying, such as cardiac or respiratory arrest, omplications that Immediate Cause (Final disease or condition resulting in death) **Physician** Houn /Medical (or as/a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical as the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached Ö 9 Unknown 9 Unknown þ تے Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 Probably **Y**Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24a. Was an 1□ Yes 2☑No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident fter death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 508 449ex55

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year

ORIGINAL

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itemstates Maryland 12874tthenton Paint and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Wood gewood Rel Baltimone 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 215301144 Director 221934 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2 ☐ No Directo 10g. Citizen of What Country? 10e. Street and Number 1017 Wedgewood Road 21229 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married THES 2□ No Yes, Give ear or Dates: 1 ☐ Yes 2 ☐ HO Specify: Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Menfal Hyglene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) John D. Capanos Elementary/Secondary (0-12) College (1-4or 5+) tactory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Helen Connor ပ္ longue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Mill Ave. Taney Taun, MD 21787 Tammi Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 ☐ Cremation Garrison Forest 12/13/2007 Baltimore, MI 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Varan C Greene French Services 4905 York And Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONCER OlOD 6 MONTES /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Division or Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

u Dy r	Part II. Other significant conditions	contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow							
analdilloo				24a. Was an autopsy autopsy performed? 1 Yes 2 No							
2	25. Was case referred to medical	26. Place of Death (Check only one)									
2	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO/	e 5. Kesidence 6 □Other (Specify)								
allon.	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred							
5	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Cal		hysician: To the best of my knowledge, death occurred a miner: On the basis of examination and/or investigation,									

State

29c. License number 8215

29d. Date signed (Month, Day, Year) 12/5/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Greene

29b. Signature and title of certifier

MD 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene o o

			1 - For State Registrar		rtificate of	Death	Reg.	2001	39938					
۲	Physici	an	Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death					
	/Medic	cal	Henry J. Thomas		Ab. Oits Town		cember	8, 2007						
	Examin	er	4a. Facility Name (If not institution, give street and notes 210 Beachwood Road	umper)	Pasade	r Location of Death		4c. County of Death Anne Arundel						
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign suntry)					
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	eation				10d. Inside City Limits					
	faryla shov	ō			Cation				1 ☐ Yes 2 ☑ No					
	the A	ect	Maryland Anne Arundel	Pasadena	10f. Zip Code		10a	Citizen of What Co	A					
	3a or	Funeral Directo	210 Beachwood Road		2112	2		ited Stat	-					
	death	nera		cedent Ever in U.S. 13.		lispanic Origin? (Specify an, Mexican, Puerto Ric		14. Race - Ame	erican Indian,					
9	after or ite mine	/ Fu	1 Never Married 2 Married 1 X Yes	2 □ No	1 ⊡Yes 2 🛣 No		an, etc.)	Black, Whit	e, etc.					
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	q p	3LXWidowed 4 LIDivorced Year or	Dates: WW II			10	' ' W	hite					
15	in 72 "nat ledica	Completed by	15. Decedent's Education (Specify only highest grade completed	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working d)		o. Kind of Business	rindustry					
212	y within giene. r than " the Med	шо	Elementary/Secondary (0-12) College n/a	(1-4or 5+)	rinter			City of	Baltimore					
bu	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fi	irst, Middle, Mai							
Maryland 2121	12 should be filed within 'n and Mental Hygiene. 7 Is marked other than " traumatic event, the Mec	P	Henry Thomas			Mary Jenki	ns		,					
Nar	12 sh hand 7 Ism rraum		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural R		•	•					
	1 and Healt em 2	1	Michael H. Thomas (son)	20b. Place of Dispo	sition (Name of	Lake Dr. E		CITY, MD						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 N Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	comptony orga	matory or other plac			rooklyn P						
alti-	mit. F partme oortan Injur													
ä	permi Depar Impor any Ir		J. Wayne	Osterling Mc	204 Mount	iyniak rune ain Road Pa	rai Hom sadena.	e, P.A. MD 2112	2					
	100		23a. P. x1. Enter the disease, or complications that shock, or heart ailure. List only one cause or						Approximate Interval Between					
-8	Physician	М	Immediate Cause (Final	1etastatic	Canc				3 Weeks					
MA.	/Medical Examiner		disease To Tiliform resulting in death) a. /// Cancer											
		j.	Sequentially list conditions, b. Due to	o (or as a consequence of):										
	nred / K. I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events c	(
oʻ	execting and and rial-tra	Еха	resulting in death) Last C	o (or as a consequence of):	·									
68760,	rtificate be executed ng physician and and as the burial-transit	Wedical	d											
			IF FEMALE:											
Box	law requires that the death ce as been signed by the attendir 2 should be detached for use	Physician/	23b. Was decedent pregnant		Ectopic pregnancy	у		23d. Date of de Month	livery Day Year					
P.O.	the de	ysic	in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify) _				,					
	that i	y Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?					
Records,	quires n sign	ed by					1 ☐ Yes	2 X No 3□P	robably 4 Dunknown					
ပ္ပ	aw re is bee 2 sho	Completed				Ĩ	24a. Was an	24b. Were at	utopsy findings available					
Ä	The lav ate has page 2 :	mo	,				autopsy performed 1 Yes 2	d? death? No 1 ☐ Yes	completion of cause of					
Vital	ding Physician: The Int. After this certificate ha funeral director, page	Be C	25. Was case referred to medical examiner?			26. Place of Death (C		X:1						
or	Physic this c	입	1 ☐ Yes 2 No Hospital: 1 [Inpatient 2 ER/Outpatier		4 ☐ Nursing Home		e 6 □Other (Spe	cify)					
n	ding l	ion:	1 Natural 5 Pending (Mo	e of Injury onth, Day Year) 28b. Time o Injury	Wor	ryat 'k? Yes 2 ∐ No	. Describe how	injury occurred						
Division	Attending r death. ector: After by the funer	ficat	3 Suicide 6 Could not be 28e. Pla	be of injury - At home, farm, str			Location (Stree	et and Number or R	ural Route Number,					
Οį	al or / s after il Dire	Certification:	4 ☐ Homicide determined bui	ding, etc. (Specify)	•		City or Town, S	State)						
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To t (Check only one) 2 Medical Examiner: On the	ne best of my knowledge, death basis of examination and/or in anner stated.	h occurred at the til vestigation, in my o	me, date and place, and opinion, death occurred	I due to the caus at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)					
	To the within To the Somple	Me	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed (Mont	th, Day, Year)					
			Mescy Dungman		DY	14477		12/10/	2007					
	121		30. Name and address of person who completed ca			Liga Si.	MONTO	MD.						
	611		bei N Carolina S	+ Room 714	3 Da	timore	MD	21287						
	Sta Registr		31. Date filed (Month, Day, Year) 32.007	Registrar's Signature	carles									

DHMH 17 Rev 1/2001

			1 - State Of Ma Registrar		artment of Health and N rtificate of Death	lental Hygid Reg	ene g. No. 2007	39939			
Į,	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death			
きを	/Medic	al	Lillian 4a. Facility Name (If not institution, give street and number)		ociuk 4b. City, Town, or Location of Death	Decembe	r 10,200				
	Examin Funeral Director	er	Riverview Nursing Home	e (In yrs. last birthday) 85 Yrs.	Essex	8. Date of Birth (Month, Day, April 25	Baltim	ore			
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits			
	Maryl a-f sho ffied a	tor	Md. Baltimore	Dundalk				1 □Yes 2XNo			
	with the Marylan a or 28a-f show be notified at	Director	10e. Street and Number	1	10f. Zip Code 21 222	109	g. Citizen of What Cou USA	ntry?			
	ms 23a	Funeral	19 Sollers Point Rd. 11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specity Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri				
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	No	if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2🌠 No Specify:	Hican, etc.)	Black, White, Specify: Whi				
15-0	I within 72 ho giene. r than "natu the Medical	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Ir	dustry			
212	filed withi Hygiene. Ither than	Completed	Elementary/Secondary (0-12) College (1-4or 5	Secre)	I .	Mospital Un	iversity			
Maryland 21215-0036	S E S	To Be (17. Father's Name (<i>First, Middle, Last</i>) Rudolph Obst		18. Mother's Name Anna	E. Obst	,				
	es 1 and 2 should k of Health and Ment Item 27 Is marked r other traumatic		19a. Informant's Name/Relationship (Type. Print) Carolyn L. Crosby friend		ng Address <i>(Street and Number or Rur</i> Sollers Point Rd.		City or Town, State, Zij	o Code)			
Baltimore,	Pages 1 ament of He ant: If Item ury or other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) Crematory Dec. 20	11,	BAltimore				
Balt	permit. Page Department Important: If any Injury o		21. Signature of Fungual Service Licensee 22. Name, and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222								
			23a. Part1. Enter the disease or complications that caused shock, or heart failure list only one cause on each lin	I the death. Do not entene.	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as	a consequence of):	ctive Pulmona	y DIS	ease				
	Examiner		Sequentially list conditions, b.	a consequence or.							
	ted sit	Examiner	rr arly, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of).							
Ć	ificate be executed g physician and as the burial-transit		that initiated events c.	a consequence of):							
98760	cate be physicia the bu	edical	d								
O. Box 6	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy] Other (specify)		23d. Date of deliv	ery Day Year			
7.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?			
ecords,	require					1 ☐ Yes	2 No 3 Pro	bably 4 Unknown			
r	The lay	Completed				24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available mpletion of cause of 2 ☐ No			
<u> </u>	rslclan: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	ent 2□ FR/Outnation	Other	(Check only one)		£.)			
on or	nding Phy th. : After this s funeral d	1 Inpatient 2 Envourpatient 3 DOA April Nursing Home 5 I Residence 6 Other (Specify)									
DIVISION	al or Atter s after dea il Director d in by the	27. Manny or Death Natural S Pending Injury M S Pending Injury M S Pending Injury M S Pending Injury M S Pending Injury M S Pending Injury M Injury M Pending Injury M Pending Injury M Pending Injury In									
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•	To t withi To tl	ğ	29b. Signature and title of certifier	MD	29c. License number D0061907	290	d. Date signed (Month,	Day, Year)			
	5		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, I		Bultin	nove MI	21221			
Ī	Sta Registr			ar's Signature	E)			·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year Physician Johnnie Towler 072007 ocember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ivista Ma Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Vear Director 231 52 8305 1, 1941 66 0ct Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2√XNo Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2260 Easton Court 20602 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∏Yes ¥2 ∏No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify چ 3 Widowed ANDivorced "natural" Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Rail Road 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy Lanier **Childress** Annie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diedra Bass (Daughter) 2260 Easton Court, Waldorf, MD 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 14, 2007 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 □Cremation 3 □Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, MD 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service/Licensee Alexandria Ferry Road, Clinton, MD 20735 23 art1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner NE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? BRAIN 12 Yes To the Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 D FR/Outpatient 3 □ DOA ို funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) rson 11345 rooral Wa

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

DEC 1 3 2007

Sohnnie

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 06:20PM 10 Detember 2007 /Medical 4c. County of Death City, Town, or Location of Death titution, give stre Examiner Boltimore more Cit Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Hours Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show inportant: of Item 27 Is marked other than "natural", or Items 23a or 28a-f show inportant of Health and Medical Examiner must be notified at one. 1 √es 2 No Funeral Director more 10e. Street and Number 10g. Citizen of What Country? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mjddle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Notice) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Woodlawn 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 1216 ٥ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a onsequence of): **Physician** /Medical Examiner c enuplish pathy Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an lardize arres certificate has Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**N**0 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar Baltimore

Registrar's Signat

		For State Registrar	State of Maryla	nd / Dep		Health and	Mental Hyg	•	7 39912
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Funeral Director			Sex 7. Age (In yrs	89 Yrs.		If Under 24 Hr		918 9. B	irthplace (State or Foreign Country) ryland
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ath with t s 23a or 2 nust be n	Funeral Director	2023 Druid Par			10f. Zip Code 2121			0g. Citizen of What C	
ours after de ral", or item Examiner n	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	12. Was Decedent Ever in the Armed Forces? 1	0.5.	d. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 X No		Specify Yes of No- erto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
be filed within 72 hours after death with the Marylar Hygiene. All Hygiene, and other than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Giv	edent's Usual Occu re kind of work done . DO NOT use retire Lroom	pation e during most of w ed)	orking	16b. Kind of Busines Advertisi	
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and 2 sh ealth and m 27 is m		Robert V. Todd,	Jr son	202	3 Druid Pa	ark Driv	e, Baltim		21211
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8		30. Name and address of person w		em 23a) (Type	e, Print) McMo	21A1 1L	SPITAI	Selection of the second	12 2007
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig		alles	-10.00	1111		

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H	Funeral		5. Social Security Number 6. S		(In yrs. last birt	thday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birt	h	0 Pir	hpiace (State or Foreig	gn
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O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic _I 5 □ Other (s		:у				23d. Date of de Month	livery Day Year	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** December MARY LOUISE WILLIAMS 8 2007 5:25 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1941 HARLEM AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🛛 F Director 217-38-9104 67 FEB. 28 1940 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1XXYes 2 □ No Director MARYLAND N/ABALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1941 HARLEM AVENUE U.S.A. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X**Xio If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade HOMECARE CARETAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE LEE ROBINSON SR. 2 FLORENCE . PAYNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. William/Daughter 1941 Harlem Ave., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State permit. Pages 1
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Important: If ite
any injury or ot
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND 12-14-07 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signature of Funeral Service Licenaee MILMA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
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State

31. Date filed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caltert

histrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 **Physician** Gary Wade Woodman 2007 12:35 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Year) 9/11/1943 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2□F 64rs. 215-42-5011 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2∑QNo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States 8632 Saxon Circle 21236 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married White Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self employed permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygien. Important: If Item 27 Is marked other the any Injury or other traumatic access the statement of the statement carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norma Lilly unk. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary H. Woodman/ wife 8632 Saxon Circle Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) ecember 15, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air Final Service Lice eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signatur 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CARCINOMA, METASTATIC **Physician** MONTHS /Medical Due to (or as a consequence of): Examiner 4EARS HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-transi Due to (or as a consequence of): physician a Physician/Medical IF FEMALE ed by the attending detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2, Z/No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HoSPICE ۵ 1 ☐ Yes 2**5**No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/ Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

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Vital

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Division

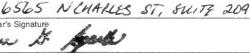
Woodman

State Registrar 31. Date filed (Month, Day, Year) DEC 1 3 2007

DANIEUE DOBERMAN,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D64395

DECEMBER 12, 2007

BALTIMORE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 16:45 PM 2007 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St Agnes HOSPITAL Baltimore, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5 24 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days 1□M 2 F 218-60-6987 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Funeral Director more 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) Decedent Ever in U.S. d Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working the DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 nompson 19a. Informart's Name/Relationship (Type. P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Int) (Daughter) Balton MD 21216 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Ohnson ω Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12/17/09 ansdown, MO 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licensee Tatalle # Harris X. M. 23270. North Av. Ba
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2222PW. North Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encephalopathi hypoxic Physician week /Medical Due to (or as a consequence of): Examiner Asthma xacerba week Se pientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Asthma years burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe oleanir 1 □ Yes 2 □ Wo 1□ Yes 2. □No Vital Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Williams

State Registrar

BODDU 31. Date filed (Month, Day, Year)

NEERAJA ST AGNEL 32. Registrar's Signature

30, Namé and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

Dec. 10, 2007

9005 (ATON AVENUE

07-09551	
Kyle Wilson	

(yle	Wilson		State of State of State of State of State of State Registrar	of Maryland /		rtment of <i>tificate of</i>		and	Mental		Reg. No. 2	00	7 3994
	Physici	an/	Decedent's Name (First, Middle,Last)					-		2. Date of De Month	ath	ar	3. Time of Death
Wed	ical Exami		Kyle Colin Wi 4a. Facility Name (if not institution, give				b. City, Town	orlo	cation of D	Decemb	er 9, 2007 Yea	of Death	1338 hrs
			Anne Arundel Medical Cent				Annapoli		odilon or b		Anne Ar		
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. Ia	st birthday)	If Under 1	Year	If Under 2	4Hrs. 8. Date of E	Birth (MM/DD/YYY)	() 9. Birt	hplace (State or n DISTRICT OF
	Director		214-15-1602	M 2 F		36 Yrs.	Months [Days	Hours	Min. Aug 1	4, 1971	Cor	untry) Columbia
	y		Usual Residence of Decedent		On City	Town or Location							10d. Inside City Limits
	ow any	l	10a. State 10b. County					1 .					1 Yes 2 X No
	Aaryland 28a-f show i at once.	향	Virginia Albeman	ite		Charlot	10f. Zip Coo				10g. Citizen of W	hat Cour	
	he Ma or 28 iffed a	Director	201 Burton Court					229	01		USA		ŕ
J	with the Maryland ns 23a or 28a-f sho be notified at once.		11. Marital Status	12. Was Decedent E	ver in U.		Decedent of	f Hispa	nic Origin?	(Specify Yes or I	No- 14. Race	e - Ameri	can Indian, Black,
Q	death or iten	Funeral	1 X Never Married 2 Married	Armed Forces? 1 Yes 2	X No					uerto Rican, etc.)		te, etc.	
	s after ral", c	by		If Yes, Give Year or Dates:	1 - 1 - D		Yes 2 X			d af		Whi	
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	5-0(led wi Hygier other		17. Father's Name (First, Middle, Last)					18	.Mother's N	Name (First, Middle	, Maiden Surname	e)	
Virginia Albemarie Charlottesville 10g. Citizen of What Co. 10g. Citiz								7:- 0-4-)					
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	ore, MC ss 1 and 2 s of Health a If item 27 her traums		20a. Method of Disposition	_		Place of Disposi	tion (Name o			Date	20c. Location	- City or	Town, State
	nore ages 1 nt of 1 nt: If other		1 Burial 2 X Cremation 3	Removal from State		crematory or oth tro Cre		In	nc. 1	12/11/07	Baltim	ore.	Maryland
	Baltimore, MC permit. Pages 1 and 2 sin Department of Health an Important: If item 27 injury or other traums	l	4 Donation 5 Other Specify: 21. Signature of Funeral Section Licens	see			-						-
	iii iii De œ	- 9	Thomas Gregor			29	9"Fred	eri	ck Ro	oad Balti	more, Ma	ryle	and 21228
	Physician /Medical		23a. Part I. Enter the disease, or complifatiure. List only one cause on each	ications that caused th th line.	ne death.	Do not enter th	ne mode of dy	ing, su	uch as card	diac or respiratory a	arrest, shock, or he	art .	Approximate Interval Between Onset and
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			Sequentially list conditions, b	oue to (or as a consec	fuerice o	1).							
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	D, be exe sician unial -	ledical		AMENDED #23	a,2/, G874	penuii,go/ _12/13/	4, 12/1 /07 JH	1/0/	11				
	Box 68760, death certificate be the attending physical of for use as the buri	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		nancy	tal death	3	Ectopic p	regnancy	23d. Date of Month		y Day Year
	lox 6876 leath certificate e attending phy for use as the	Physician/N	past 12 months?	4 Pregnant at ti	me of de	oth -	her (Specify)						
	BOX he death true atte	hys	1 Yes 2 No 9 Unknown	9 Unknown	h		and sale discountry		on in Dort	1 23a Di	tobacco use con	tribute to	the cause of death?
,	P.O. Es that the d	by	Part II. Other significant conditions	contributing to death	DUL HOL II	estriting in the t	inderlying cat	use giv	eninrait			,	bably 4 Unknown
	of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	Completed						_		24a. W		Were a	utopsy findings available
	COF e law r e has b ge 2 sh	힐								pe	topsy rformed?	death?	completion of cause of
į	ital Recician: The certificate rector, page		25. Was case referred to medical				26.F	Place o	f Death (C	heck only one)	s 2 No	1 🗸 Y	es 2 No
	Vita ysicia his cer directe	o Be		ospital: 1 Inpatien	t 2 🗸	ER/Outpatient			thor:	Nursing Home 5	Residence 6	Othe	or:
	n of ding Ph L. After t funeral	ը 1:1	27. Manner of Death	28a. Date of Injury (Month, Day,Ye	y ar)	28b. Time of I	· · · .		at Work?		e how injury occu	rred	
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01	Division tal or Attendii rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	.	ıry - At h	ome, farm, stree	et, factory, off	fice bui	ilding, etc.	28f. Location or Town		ber or Ri	ural Route Number, City
,	lospita hours uneral	ᇹ	29a. Certifier	an: To the best of my	knowlod	no dooth coolir	rod at the tim	o data	and place	and due to the co	auco(c) and mann	or se ets	ted
\vee	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Meercal	one) 2 Medical Examiner:	On the basis of exam	ination a	nd/or investigat	ion, in my op	inion, o	death occu	rred at the time, da	ate and place, and	due to ti	he cause(s)
	. ≧ ≧ ≅ Š	NE NE	29b. Signature and title of certifier	and manner stated.		•	29c. Li	cense	number		29d. Date sig	ned (Mo	onth, Day,Year)
	N.		his his	mr			0	.C.M	ιĒ.		Decembe	r 10, 2	007
	JA		30. Name and address of person who o				t Daltim-	ro N	ID 0400	1			
				edical Examiner 32. Registrar		Penn Stree	et, Baitimo	re, IV	עו 2120	1			
	S Regis	tate	31. Date filed (Month, Day, Year)		o orgitali	le de	100						

P.O. Box 68760 THEODORE WAGA Records, Division or Vital To the Hospital o within 24 hours aft To the Funeral Di

a.m.

DECEMBER

DR. ERNESTINE WRIHHT 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year, 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DEC 1

3. Registrar's Signature

Registrar

07-09602 **UNK UNK**

Gary Wayne Zoppo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year December 11, 2007 0725 hrs **Medical Examiner** Gary Wayne Zoppo 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4801 Erdman Avenue **Baltimore** N/A 9. Birthplace (State or Foreign Mary Land 5. Social Security Number If Under 1 Year | If Under 24Hrs. Date of Birth(MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 215-44-9136 Dec 24. 1 🗓 м Country) 1947 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Allegany Cumberland death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11313 Sunny Lane NE 21502 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 X Married Yes permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mernfal Hygien Department of Department of Filem 27 is marked other than "matural", of injury or other traumatic event, the Medical Examiner; injury or other traumatic event, the Medical Examiner; 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 8 Security Guard Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Zoppo Jeanette Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Zoppo, Wife 4915 Wright Avenue Baltimore, Maryland 21205 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 X Cremation 3 crematory or other place) 12/12/07 Metro Crematory Inc. Baltimore, Maryland Donation 5 Other Specify. 21. Signature of Funeral Service Licensee
Thomas Gregor 2 Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical attending physician a XUNPENDED MENDED. #23a.27.28a.b.e.&f. perME.g875, 1/11/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) director. Be Hospital: 1 Other; this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes မ After 1 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: FOUND: 1 X Natural Pending Yes 2 No within 24 hours after death.

To the Funeral Director: empletely filled in by the Dec 11, 2007 *9724 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) (Specify) Sidewalk 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 12-12-07 Norma MUmarti, MID O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

31. Date filed (Month, Day, Year)

DEC 1 3

gistrar's Signature

ORIGINAL

			for State	State of Ma	aryland / Dep	partment of Fertificate of		Mental Hy		2007	20050
			Registrar 1. Decedent's Name (First, Middle, Las	s+1	C	ertilicate of	Deam	2. Date of D	Reg. No.	2001	3. Time of Death
	Physici	an						Month	Day		
4	/Medic		Bao H. 4a. Facility Name (If not institution, give	Zheng		4h City Town	or Location of Dea	Dec.	10,	2007 County of Death	2:36 P
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	Director		060-72-9765	□M 2⊠F	40 Yrs.	Months Days	Hours Min	June	27 . 1	967 Cou	ntry) China
i i	D		Usual Residence of Decedent					- Journe			
	show	_	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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30	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub □ Yes 2 No	an, Mexican, Pue	specify Yes of N rto Rican, etc.)		Black, White, Specify:	etc.
15-0036	thou atura	ed	15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occu	pation		16b. Kir	nd of Business/In	inese ndustry
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	s 1 and 2 should F Health and Mer tem 27 Is marke other traumatic		De Chen / Ex-Husba	and		Columbia	Road Ap				
saltimore,	e = 5		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	cemetery, ci	position (Name of rematory or other pla	ce)	Date	20c. Lo	cation - City or Te	own, State
	permit. Pag Department Important: any injury once.		4 □ Donation 5 □ Other (Specifi			del Cremat 22. Name and Addre		-18-07	Oden	nton, Ma	ryland
g	perm Depa Impo any i		21. Signature of Funeral Service Licen	Marcel		Donaldson	Funeral	Home &	Crema	atory, P	.A.
			23a. Part1. Enter the disease, or com	plications that saused		1411 Anna	DOTTS TO	au Ouei	LUII	Marylan	d 21113 Approximate
L			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ie.	mor are mode or dy	ng, saon as oarar	ao or respiratory	arrost,		Interval Between Onset and Death
S	Physician /Medical		disease or condition resulting in death)	a	onitis					-	10 days
	Examiner			Due to (or as	a consequence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):						
	d d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C							
Ď	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8/PU	icate be executed physician and s the burial-transit	dical	•	d							
	ertifica ing ph e as t	Med	IF FEMALE:								
o n	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	:y		2	23d. Date of deliv Month	very Day Year
	the de y the a iched f	/sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _					
7.	that the sed by detac		Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to t	the cause of death?
Kecords,	The law requires that te has been signed by page 2 should be deta	d by		-				1 🗆	Yes 2	☑No 3□Pro	bably 4 Unknown
Ö	v req been shoul	Completed						24a. Wa	0.00	24h Wore out	anny findings available
ğ L	The lavate has	m						aut	opsy formed?	death?	opsy findings available ompletion of cause of
		ပို	25. Was case referred to medical				Of Diago of Da	1 Yes		1 ☐ Yes	2 No
		o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Innatie	nt 2 ☐ ER/Outpati	ent 3 DOA Oti	oor:	eath (Check only		3 □Other (Speci	(6.1)
	g Phy er this eral c	H-1	27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Inju		28d. Describe			197
JIVISION	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Injury		Yes 2 □ No				
<u> </u>	Attendi er death. rector: A by the fu	iitica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc	iry - At home, farm, s	street, factory, office			(Street and		ral Route Number,
5	Ital on rs after all on all on all on all on the second se	Certification:		- 3,				1			
	Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical Exan	ysician: To the best oniner: On the basis of	examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	ce, and due to th	e cause(s) e, date and	and manner as a	stated. to the cause(s)
	To the Hospital or Attending Phys within Ev hours after death. To the Funeral Director: After this completely filled in by the funeral di	Med	one) 29b. Signature and title of certifier	and manner sta	ited.	29c, Licens	se number		29d Det	e signed (Month,	Day Year)
	N I I		255. Signature and title difference	2000	J						
	^		' 0		0 ~~	D 45	5157		Dece	ember 11	, 2007
	1		30. Name and address of person who		eath (Item 23a) (Typ pers Farm		Columbia	Mowari 1	and o	10/4	
	Sta	ite	Tin O. Maung, MD 31. Date filed (Month, Day, Year)	22 Dollete	ar's Signature		COTUMDIE	a, rialyl	anu Z	. 1044	
	Registr		DEC 1 3 2	007	yas B	South					
DHN	MH 17 Rev 1/2	001		1-00							

Registrar DHMH 17 Rev 1/2001 1- State Registrar Amend #21, perF.D. 0875, 1/29/08 TTCertificate of Death

Division or Vital Records, P.O. Box 68760,

			24a. Was an autopsy performed? 1□ Yes 2 🌠 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)						
1 XYes 2 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatien	1 M inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specify)							
27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury	f 28c. Injury at Work?	28d Describe bow injury Subject, driver	of motorcycle collide					
2 X Accident investigation	100 . 27 . 2007	P ^M 1□Yes 2¶∑No		th pickup truck					
3 Suicide 6 Could not b 4 Homicide determined		reet, factory, office	28f. Location <i>(Street and Number or Rural Route Number, City or Town, State)</i> Interstate 495 near hitchie—Marlboro Rd. Forestville, N						
_	Roadway		Titchie-Marlbor	o Rd. Forestville, MD					
	nysician: To the best of my knowledge, deal miner: On the basis of examination and/or in and mannerstated.	h occurred at the time, date and place	e, and due to the cause(s)	and manner as stated.					
29b. Signature and title of certifier	1 //	29c. License number	29d. Date	e signed (Month, Day, Year)					
• //	1 Vm	O.C.M.E.	Janua	ary 28, 2008					
30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)							
MARY G. RIPPL	ϵ , m) 111	Penn Street, Balt	imore, Maryl	and 21201					
31. Date filed (Month, Day, Year)	32. Registrar's Signature	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3:30

Birthplace (State or Foreign Country)

New York

10d. Inside City Limits

1 ☐ Yes 2 No

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian

Black, White, etc.

Specify: Black

20c. Location - City or Town, State

23d. Date of delivery

Day

Year

Month

Silver Spring, MD

16b. Kind of Business/Industry

Bus Service

USA

Prince George's

Рм

State Registrar

funeral

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** November 29 2007 7:00 Smith W. Allnutt Jr. /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5930 Great Star Drive Unit 405 Clarksville Howard If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Director 577 10 8292 90 July 21, 1917 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show notified at 1 ☐ Yes 2 No MD 28a-f Howard Clarksville Direct the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be 5930 Great Star Drive Unit 405 21029 United States death Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

marked other than
umatic event. In a Me Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) th and Mental H Be Smith W. Allnutt Sr. Margaret Waters ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tam 27 ls Margaret G. Allnutt/Wife 5930 Great Star Drive Unit 405 Clarksville, MD 21029 Itam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: It any injury o pnce. 4 Donation 5 Mother (Specify) entombment Crest Lawn Mem. Gard, 12/3/2007 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition arlow **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last physicien at the burial-t Due to (or as a consequence of) Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a. Was an has page certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thir 24 hours after continue of the Funeral Director: A investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1he 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tol DO9526 Centes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CoLumbia Rd. 21044 11085 Little ATHXENT 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar NOV 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.									
State of Maryland / Department of Health and Mental Hygiene									
Certificate of Death	Reg. No. 2007	39953							
st, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death							

/Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

•eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

To the Hos within 24 h To the Fur completely	
15+1	

John Trede Buckholtz November 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I Under 24 Hrs. 8. Date of Birth Day Vender 1 Year I Under 1 Year I Under 1 Year I Under 1 Year Min. 4 Month Day Vender 1 Year I Under 1 Year I Year	Day Year 25, 2007 8:14 PM
John Trede Buckholtz 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Matter Sex If Under 1 Year If Under 1 Y	
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Month Day Vender 1 Year If Under 24 Hrs. 8. Date of Birth Day Vender 1 Year 1 June 1 Year 1 June 2 Year 1 J	,
Shady Grove Adventist Hospital Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day Year If Under 24 Hrs. 10 June 1	4c. County of Death
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	To. Obanty of Boats
J. Goodal Geodity Harris Davis House Min /Month Day Vo	Montgomery
	ar) 9. Birthplace (State or Foreign Country)
	1935 Washington, DC
Usual Residence of Decedent	-
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
5	1 ☐ Yes 2 ☐ x No
Maryland Montgomery Rockville	Citizen of What Country?
loe. direct and Mainter	
13311 Oriental Street 20853	USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
T I □ Never Married 21X Married I 11X Yes 2 □ No	
If Yes, Give 1 Yes 2 No Specify: Year or Dates: 1952-55	Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation 16b	. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	. Kind of Business/madally
Elementary/Secondary (0-12) College (1-4or 5+)	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer	Washington Gas
	den Surname)
Henry H. Buckholtz Margaret Anto	nia Tippett
	**
Jeanette Buckholtz/Wife 13311 Oriental Street, Rockvil	1e, MD 20853
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	c. Location - City or Town, State
1X Bunal 2 Cremation 3 Hemoval from State NOV . 29	
4 Definition of Definition (Openity)	kville, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral	Home Inc.
Sound S Sound Sound Sound University Blvd, W., Si	lver Spring, MD 2090
23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Cause (Final	Onset and Death
disease or condition resulting in death) a. Sepsis	Acute
Due to (or as a consequence of):	
Sequentially list conditions b. Non-Hodgkins Lymphoma	Chronic
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
cause. Enter Underlying Cause (Disease or Injury	
that initiated events C.	
resulting in death) Last Due to (or es a consequence of):	
resulting in death) Last Due to (or es a consequence of):	
resulting in death) Last Due to (or es a consequence of): d.	
resulting in death) Last Due to (or es a consequence of): d.	
d IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	23d. Date of delivery
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1	23d. Date of delivery Month Day Year
JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Variable Variabl	Month Day Year Month Day Year Documents of death? 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Documents of Nunknown Death Probably 4 Nunknown Complete of Completion of Course of death? 1 Yes 2 No Death Probably 4 Nunknown Death Probably 4
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Month Day Year Month Day Year Month Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day
Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of to est to the part of the to all the part of the part of the to all the part of the part of the part of the to all the part of t	Month Day Year Month Day Year Month Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day Year A Day

Division or Vital Records, P.O. Box 68760 filled in by the funeral within 24 hours a To the Funeral

> State Registrar

10

Medical

29a. Certifier

29b. Signature and title of certifie

Michelle V.

and manner stated.

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Price,

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D50778

11055 Little Patuxent Pkwy, Columbia

29d. Date signed (Month, Day, Year)

21044

11/28/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Harold Beck November 26, 2007 1:35 P. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Summerville of Potomac Montgomery Potomac 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
Sept. 21, 1912 New York If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 X M 2 □ F Director 052-01-6935 95 Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 20854 11215 Seven Locks Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must to Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer Seller 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Pankin Louis Beck ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9710 Leather Fern Terrace, Montgomery Village, Md 19a. Informant's Name/Relationship (Type. Print) Lawrence A. Beck - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Star of David Cem. 11/30/2007 N. Lauderdale, Florida Ò 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. Donald 20852 1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Immediate Cause (Final Months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached f 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diabetes Mellitus autopsy performed' **X**□ No 25. Was case referred to medical examiner?
1 ☐ Yes No funeral director, 26. Place of Death (Check only one) Be Other: $4\square$ Nursing Home $5\square$ Residence 6 * Other (Specify) AssistedHospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☐Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Division or Vital Records,

al or Attending I neral Director: / / filled in by the fi 24 hours a Hospital To the within 2

4 ☐ Homicide

29a. Certifier (Check only one)

29b. Signatu

208, Rockville, Maryland 20850 Ran Passi 15225 Shady Grove Road, 32. Bigistrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

November 27, 2007

	ckdor	ff S - For State	State of Maryland	Departm / <i>Certific</i>	ent of	Health a Death	na went		1	200	7 399	
	F	tegistrar 1. Decedent's Name (First, Mide	(dle l ast)	Certino	ale or	Death		2. Date of Dea			3. Time of Death	
Physicia dical Exami	1117	David Peter B				Month Novembe	r 22, 2	007	2259 hrs			
		4a. Facility Name (if not instituti	tion, give street and number)	41	4b. City, Town, or Location of Death				County of Death		
* *		3724 Damascus Roa			uli da i s	Sunshine If Under 1 Y		24Hrs 8 Date of B		DD/YYYY) 9. Birth	pplace (State or	
Funeral		5. Social Security Number		ge (In yrs. last bir			ays Hours	Min		Foreign	^{ntry)} Maryland	
Director		216-94-2973	1 X M 2 F	40	Yrs.			07/15	/190	0 /	Maryland	
any		Usual Residence of Decedent 10a. State 10b. County	ty	10c. City, Town	n or Location	on					10d. Inside City Limits	
* .	_ [Maryland Fre	derick	Urt	oana						1 Yes 2 XXNo	
arylan 8a-f sl at one	cto	10e. Street and Number				10f. Zip Cod	e		10g. Citi	zen of What Coun	try?	
vith the Maryland s 23a or 28a-f show a e notified at once.	Dir	9417 Prospect	Hill			217				Inited St		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentals Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examinor must be notified at once	Funeral Director	11. Marital Status	12. Was Deceden		13. Was	s Decedent of	Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Americ White, etc.	can Indian, Black,	
death or iter must	un ₋		1 Yes 2	X No		Yes 2 X				Specify: Whi	te	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica	B B	John Brockdor					Donna	a Virginia nber or Rural Route N	Wal	1	Zin Code)	
21 hould nd Me is ma	유	19a. Informant's Name/Relatio		1							, Zip Code)	
MC and 2 slatth at m 27		John Brockdor 20a. Method of Disposition	ff / Father			eeling sition (Name o		Palm Coas Date	20c.	Location - City or	Town, State	
of Hear fr			tion 3 Removal from S	State crem	atory or oth			Nov. 26,	_		7 7 1	
Page ment tant:		4 Donation & Other	Specify	Kest	_			2007			Maryland	
3alt ermit Depart mpor njury		21. Signature of Funeral Servi	ice Licensee		Re	sthavei	Fune	al Servic Itn. Hwy.	es,	Skkot Co	dy P.A.	
		23a Part I. Enter the disease,	or complications that cause	ed the death. Do	not enter t	the mode of dy	ing, such as	cardiac or respiratory	arrest, sh	nock, or heart	Approximate Interva	
Physician /Mcdical		failure List only of e cau	use on each line.								Death	
aminer		Immediate Cause (Final disea or condition resulting in death			au anu c	Onest						
		Sequentially list conditions,	b								 -	
	ner	if any, leading to immediate	Due to (or as a cor	nsequence of):								
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687 certific	ian/	23b. Was decedent pregnant i past 12 months?	LIVO DITAL	at time of death	_	etal death Other (Specify		nc pregnancy	4	Wichian	24,	
SOX leath c e atter for us	ysic	1 Yes 2 No 9			3 0	Milei (Opcon)						
ords, P.O. Be v requires that the de s been signed by the should be detached f	Ph	Part II. Other significant cor	nditions contributing to de	eath but not resu	Iting in the	underlying ca	use given in F				o the cause of death?	
P.O. es that the signed by be detach	b S									551-55-5	obably 4 Unknow	
S E G	Completed								utopsy	prior to	autopsy findings availal completion of cause o	
red pee	E D	/							erformed es 2	? death?		
e law reque has bee	ြင္ပ	25. Was case referred to me	edical			26.		h (Check only one)				
Record: The law required tiffcate has bee	m	examiner?	Hospital:	atient 2 EF	R/Outpatier	nt 3 DO/	Other ₄	Nursing Home 5		idence 6 🗸 Oth	er: Scene	
Vital Record sician: The law requisecutificate has bee director, page 2 should record.	1 5	27. Manner of Death	29a Date of	Injury 28 ay,Year)	Bb. Time of	· · ·	c. Injury at Wo	 ISubject s 	ibe how shot se	injury occurred		
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on of Vital Records, ending Physician: The law require zath. or: After this certificate has been si the finneral director, page 2 should b	on: To	1 Natural 5	Investigation Nov 22, 20	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, e						28f. Location (Street and Number or Rural Route Number, City or Town, State) 3724 Damascus Road, Sunshine, MD		
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			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Depa <i>Cer</i>	rtment tificate	t of Ho	ealth and Death		Reg. I		07	
js:	Physici /Medio	al	Mary B	ARRY					Month	2	3 0	Year	3. Time of Death 4.130 A M
7	Examir	er	4a. Facility Name (If not institution, give s 20514 Campbell Co 5. Social Security Number 6. Sex	urt 7. Age (In yrs.		Н	lager	Stown If Under 24 H Hours M	rs. 8. Date (of Birth h, Day, Yea		ingt 9. Birthp Cour	place (State or Foreign htry)
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1215-0036 within 72 hours after deeth with the Maryland ene. then "natural, or iteme 23s or 28e-f show he Medical Examiner must be notified at		y Funeral Director	10e. Street and Number 20514 Campbell Co		J.S. 13. V	10f. Zip	Code 21 ent of Hiselfy Cuban	740 spanic Origin? n, Mexican, Pu Specity:	(Specify Yes of erto Rican, etc.)			A - Americ c, White,	an Indian, etc.
id 21215-003	Hygint, I	Be Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ation	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse 18. Mother's Name (First, Middle, M.						6b. Kind of Business/Industry Hospital		
Maryland	0 a = 9	ToB	Harry Allman 19a. Informant's Name/Relationship (Type	489	850=5.500V	2830 8		nd Number or	garet K Rural Route N	lumber, City	or Town, S		
altimore,	permit. Pages 1 and 1 Department of Health Important: If Item 27 any injury or other tr once.		Maureen Ferguson : 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service License	20b. learnoval from State	cemetery, crem thedral	ceme	e of ther place tery)	Mager /7/07 Minnic	20c.	crant	on .	d 2174() own, State Pennsylvani
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P.O. Box 6	death certi e ettending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	Sc. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3□	Ectopic pre Other (spe					23d. Date Mon		ory Day Year
	law requires that the es been signed by th 2 should be deteche	þ	Part II. Other significant conditions conf	ributing to death but not res	sulting in the un	derlying ca	iuse giver	n in Part I.					ne cause of death? ably 4 ∐Unknown
tal Rec	The ete h	Be Completed	25. Was case referred to medical					26 Place of D	-		pr	ere auto for to cor eath?	psy findings available npletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours eiter deals of the Funatel Director. After this certific completely filled in by the funeral director,	္	27. Manner of Death 1	Hospital:					Home 5	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			()
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)	To T Com	Σ	29b. Signature and title of certifier	Cen		7	License	9471		12	ate signed	(Month,	Day, Year)
10	4-10+1		30. Name and address of person who cor Dr. Kerns 22	911 Jefter	son K		5	miths	burg	MX	21	183	
	Sta Registr		31. Date filed (MorDEC. 723 200	32. Pgistrar's Signa	ature								

ORIGINAL

DHMH 17 Rev 1/2001

			For State of Mar	-	epartment of H C <i>ertificate of L</i>		entai mygier Reg. i	°.2007	39958
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Frederick Brace	BILLMEY	ER		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al .	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	November	30 200 ⁷ 4c. County of Death) 10250 Am
	LXuiiiii	•	Washington County Hospital		Hagers			Washingt	
<u>محمد الرو</u> - المألج - ب	Funeral Director		217-10-7134 ^{1⊠M 2□F}	'In yrs. last birth 92 Yı	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea June 30,	9. Birth Con 1915 Mai	nplace (State or Foreign untry) cyland
	and w	-	Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town	or Location			_	10d. Inside City Limits
	Maryl -f sho fied at	ţo	Maryland Washington	Hager	stown				1 ∐Yes 2X No
	h with the 3a or 28a st be noti	Funeral Director	10e. Street and Number 13330 Unger Road		10f. Zip Code 217	42		Citizen of What Co	untry?
30	d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 77 Is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Was Decedent Event For Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: wh	e, etc.
2-003p	"natural	Be Completed b	15. Decedent's Education (Specify only highest grade completed)	16a F	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	ation furing most of work	16b	 . Kind of Business/I	ndustry
7	within iene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	· i	electronic			appliance	e repair
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Z Z	ind 2 sho alth and 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Frederick N. Billmeyer - so	ı	Mailing Address <i>(Street a</i> Sturgis Dri			-	21740
nore,	item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Disposition (Name of crematory or other place Lawn Memori Pari	e) a1 Decem	ber 4,	Location - City or	Town, State Maryland
Baltimor	permit. Page Department (Important: If any Injury or once.		21. Signature of Funeral Service Licensee		22. Name and Addres	ss of Facility Mi	nnich Fun	eral Home	the state of the s
r			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	KSTAT	TL BLAD	DER C	micer		Onset and Death 1-2 Welly.
	/Medical Examiner		resulting in death) Due to (or as a		f):				1-71,200
k		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)		TEMATURE	*			1-2 Weeps FOR YEARS
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ono	ding Phys h. After this funeral di	tion:	27. Manner of Death ↑ Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day)		jury Wor	y at k? Yes 2 □ No	28d. Describe how i	njury occurred	
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ertification:	207004011	y - At home, farr (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	e Hospita 24 hours e Funeral etely filler	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and	death occurred at the tir l/or investigation, in my c	me, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		29c. Licens	,	29d.	Date signed (Mont	
)			> Dear MD		1	146561	1 4	ov 30	, 2007
6+	4 10+1		30. Name and address of person who completed cause of dea	ath (Item 23a) (T		ROM	HAGUSTO	WN M	, 2007 10 21740.
	Sta Registr		31. Date filed (Month, Day, Year) 32. Rosstrar		Soule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sidney Allison Bowie November 28, 2007 10:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6120 Mason Springs Road Indian Head Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1**)** M 2 □ F Maryland Director 212-03-8646 90 April 21,1917 Usual Residence of Decedent filed within 72 hours after death with the Maryland la or 28a-f show t be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Charles Indian Head 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a 6120 Mason Springs Road 20640 U.S.A. Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner mo 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ X lo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hamilton Allison Bowie Jennie Elizabeth Rees 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Marie Bowie 6120 MAson Springs Rd., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pisgah United Methodist Church Pisgah, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licepse M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4270 Hawthorne Rd., Indian Head, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and Due to (or as a consequence of) physician a s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical law requires that the death certificate attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed? Yes 2010o certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home Statement 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this of ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation thin 24 hours a er death.

The Funeral Director A pmpletely filled in by the fu 1 ☐ Yes 2 ☐ No hours a er death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier a 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 2 9

2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #23a per phys 11/29/07 Certificate of Death 2. Date of Death Month Dav Veal **Physician** BARNES 2 MARY 1 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGES TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) MARCH 9, 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 ₩ F Min. MARYLAND 1928 79 Director 214-28-4805 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1 ☐ Yes 2 No Examiner must be notified Director PRINCE GEORGES HYATTSVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 20782 UNITED STATES 6000 SARGENT ROAD #106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Items 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

9TH GRADE College (1-4or 5+) HOMEMAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JANIE ELIZABETH FORD BARNES Is marked CHARLES HENRY BARNES, SR. 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tran BESSIE E. EDELEN / DAUGHTER 15720 MILLBROOK LANE, LAUREL, MARYLAND 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MATTHEWS CEMETERY NOVEMBER 29, 2007 NEWTOWN, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** hiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 1No Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Matural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063703 2410] enach lus, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Prigistrar's Signature

ORIGINAL

PARK, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0110M BURNS **Physician** 1 (ILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER Birthplace (State or Foreign Country) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number Months Days **Funeral NEW YORK** JUNE 26, 1920 87 103-12-8087 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event the Marketon. 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21666 627 OLD LOVE POINT ROAD Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1942—1945 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 \$ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION** SCHOOL TEACHER 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIE LINEHAN JOSEPH BURNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2093 MISTY HOLLOW DRIVE, WALL TOWNSHIP, N.J. 07719 ROBERT O'KEEFE/NEPHEW 20b. Place of Disposition (Name of EASTERN SHORE 20c. Location - City or Town, State 20a. Method of Disposition DECEMBER 3 1 XBunal 2 ☐ Cremation 3 ☐ Removal from State HURLOCK, MARYLAND 2007 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final V **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed bunial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): or Vital Records, P.O. Box 68760 attending physician for use as the buna Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23h. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 s has performed 2 No 2 N 1 TYPS 1☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🖍 Inpatient 1 ☐ Yes No No ၉ this 28d. Describe how injury occurred 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After Injury Division 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide after To the Hospital or within 24 hours are To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospital 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, NOV 3 0

Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Raistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1906 P M James S. Banks 35 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HICOMICO SALBBUR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□F 217-28-4718 Director 12-24-1930 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 29430 Waller Road 21875 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural" or item any injury or other traumatic control in the page 1. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 2 Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gas Station Owner & Operator 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard T. Banks, Sr. Mabel Frances Ruark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delmar, MD 21875 Jean S. Banks (Wife) 29430 Waller Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens CemeteryNov. 30, 2007 Delmar, Delaware 22. Name and Address of Facility Short Funeral Home 21. Signature of Funeral Service Linensee 13 East Grove Street Delmar, DE 19940 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 □ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1X Yes 2 No 1 Inpatient ۴ funeral To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/27/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) der PRMC, Registrar's Signature 100 E. Carroll St. Salisbury MD. 21801 pher Snyder Aristo 9 2007 State Registrar

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Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

James

			1 - For State Registrar	State of Maryland / Depa	artment of Health and Martificate of Death	fental Hygier Reg.≀	2001 33303
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	Cédras		2. Date of Death Month DEC. 3	Day ZOO7 (O:30Am
	Exami		4a. Facility Name (If not institution, give : 7673 FAIRBANKS	丁.	4b. City, Town, or Location of Death	F	Accounty of Deeth
	Funeral Director		5. Social Security Number 6. Sex 15 55 547791 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 8-19	9. Birthpface (State or Fpreign Country) DOWN CAN
	Maryland a-f show	tor	10a. State 10b. County ANNE AR	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23e or 28s	Funeral Director	10e. Street and Number 7673 TAIRANKS	ct.	10f. Zip Code 2 1076	10g. (Citizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, If a Medical Exercitival Praisi Re ricitified at	by Funer	1 ☐ Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	Nas Decedent of Hispanic Origin? (Spr f Yes, specify Cuban, Mexican, Puerto I Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	in 72 hour n "natural" Avdical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	(Give	tent's Usuaf Occupation kind of work done during most of work DO NOT use retired)	16b.	Kind of Business/Industry
2	e filed with Il Hygiene. other the	Be Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	Colfege (1-4or 5+)	RPINTER		ONSTRUCTION en Sumame)
Maryland	2 should be and Mental is marked o	ToB	LOREN'ZO M. AZ 19a. Informant's Name/Relationship (Ty)	VARADO 19b. Mailir	g Address (Street and Number of Rui	A. RIVA	Sy or Town, State, Zip Code)
			EUSENE CEDIAS, 20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b. Place of Dispo	TA RBANKS CT. HA sition (Name of natory or other place)	Date 20c.	1D · 21076 Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	MD. VETER	ANSCEMETER 12- Name and Address of Facility Daugherty Family Funeral Hi		CONSVILE, MD.
	00 E # 0		23 Part Litter the disease, or compli- shock, or heart failure. Vist of you	orlins hat caus off death Pornot enti- e cause on each line.	2601 Mountain Road or the mode of dying, such as cardiac	 Pasadena, MD. 	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	east Cancon		4 years
7	uted se	miner	Equipmentally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
8/pn, K	cate be executed physicien and the burial-transit	dical Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):			
	death certificate e attending physid for use as the	a)	200. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetaf death 3 □	Ectopic pregnancy		23d. Date of delivery
Ö.	the d y the iched	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)	OO. Diday	Month Day Year
Records,	law requires that as been signed b 2 should be deta	by	Pan II. Other significant conditions con	tributing to death but not resulting in the ur	derlying cause given in Part I.	1 Tes	o use contribute to the cause of death? 2010 No 3 Probably 4 Unknown
r	The ate h	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
or vital		To Be	25. Was case referred to medical examiner? 1 Yes 2 No He	ospital: 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4□ Nursing Ho		6 ☐Other (Specify)
	ftei	icatlon;	1.☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, stre	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	and Number or Rural Route Number,
	lo the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	al Certific	4 Homicide determined	building, etc. (Specify)		City or Town, Sta	ate)
	thin 24 the Hoothin 24 the Full mpletely	Medical	(Check only 2 Medical Examin one) 29b. Signature and title of certifier	er: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
1	2 3 7 8		> Michilas Rous	relictions	D38509	Dea	mbi < 5 2007
	6		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, F 25 11065 Li HIL PATUR	Print) Pky Columb	is Morry law	20 21044
į	Sta Registr		31. Date filed (Month, Day, Year) 201	32 Begistrar's Signature	D3850g	,	

LOBANCY A. CEDRAS

			1 - For State Registrar	State of M	aryland / D	epartme <i>Certifica</i>			nd Ment		ene2007	39	964
			Decedent's Name (First, Middle, L.	a st)						ate of Death	1	3. Time	of Death
	Physici		ANNA CATHERI	NE CANNO	ON					_{onth} CEMBI	ER 6 200	7 6.23	3 p ^M
	/Medio Examin		4a. Facility Name (If not institution, gi			4b. Cit	, Town, or	Location of			4c. County ol Dea		<u>. P</u>
	LAGIIII	e.	Chester River			Cl	este	ertow	n		Kent		
	Funeral			Sex 7. Ag	ge (In yrs. last birt			If Under 2	4 Hrs. 8. Da	te of Birth	year) 9. Bi	thplace (State	or Foreign
	Director		216-38-9038	1 □ M 2 💢 F	90	rrs. Month	Days	Hours	Min. Au	te of Birth lonth, Pay, G 13	77917 Ma	ryland	E
	P.		Usual Residence of Decedent		40.00							land in side of	Circ Limite
	arylar show		10a. State 10b. County		10c. City, Town							10d. Inside (s 2 No
	Be-f:	양	MD Kent		Chest	ertown							
	or 2	Dire	10e. Street and Number				ip Code				g. Citizen of What C	ountry?	
	ath v	rai	402 Morgnec Ro				1620				.S.A.	7	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be mailfied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 18 If Yes, Give Year or Dates:	?		edent of Hisecify Cubar 2X No	spanic Origi n, Mexican, Specify:	in? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race - Am Black, Whi Specify: V		
Ò	2 ho	ted	15. Decedent's E	Education	16a.	Decedent's Us (Give kind of v	ual Occupa	ation	of working	1	6b. Kind of Business	/Industry	
2	thin 7	Completed	(Specify only highest gi	College (1-4or	5+)	life. DO NOT	use retired,)	or working				
2	od wil	Ö	8			Iomema	ker				Own Ho	me	
p	al Hy d oth	Be (17. Father's Name (First, Middle, Las								faiden Sumame)		
yla	ould b Ment arke atic	၉	Harry V. Welch	1	_				na Sew				
Maryland	2 sh and ls m		19a. Informant's Name/Relationship								City or Town, State,	_	
2,5	is 1 and 2 of Health a item 27 ls other treu		Sharon Price	(grandda	-			ırgal	Le Far				ח שט
Baltimore,	. Pages 1 Iment of H tent: If ite jury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	ify)	cemeter	Disposition (N y, crematory of ersvil	other place le C	em. 1	2/10/	07	Sudlersy	ille,	
Ball	Departimonal Important in suny in conce.		21. Signature of Funeral Service		00510	Galen 118 W	a Fui est (s of Facility neral Cross	Home St.	of Gale	Stephen na, MD.	L. Sc 21635	haech
			23a. Part1. Enter the disease, or con- sheek, or hear failure. List only	nplications that cause y one cause on each I	d the death. Do n	ot enter the m	de of dying	g, such as c	ardiac or resp	iratory arre	st,	Approxima Interval Be	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Come	a consequence of	Hear	Jen	lue			-	Onset and	Death
	Examiner		Sequentially list conditions.	b								0	
. \	D #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	ďγ.							
h.	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to (or or	a consequence o	4).							
8760,	cate be executed physician and the burial-transit	i E		Due to (or as	a consequence c	.,.							
87	physicate the	dicai		d									
O. Box 6	Attending Physicien: The law requires that the death certific ir death. If death. Sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ⊟Ectopic 5 □ Other (23d. Date of de Month	olivery Day	Year
Division of Vital Records, P.O.	that led by deta	Y P	Part II. Other significant conditions	contributing to death I	out not resulting in	the underlying	cause give	en in Part I.	2	3e. Did tob	acco use contribute	o the cause of	death?
ds	uires n sigr	D D	OCCF) 17	ratolista	3 0	umic	-den	1 2	celin	1 🗆 Ye	s 2.1 No 3□F	robably 4]Unknown
00	aw requires tha s been signed I e should be det	iete	214 00	m & Hon	/				2	4a. Was an	24b. Were a	utopsy finding	s available
Re	he la e has	щ	O asvina & D	9 (12)	<u> </u>					autopsy perform	ied?/ death?	completion of	cause of
a	in: T ificate or. pa		25. Was case referred to medical	1				26 Place	of Death (Che			s 2 No	
₹	sicie certi	o Be	examiner?	Hospital:	ent 2 ☐ ER/Out	patient 3 🗆 [Othe	or.			nce 6 □Other (Sp	aci6/)	
ō	Phy or this oral d	: To	27. Menner of Death	28a. Date of Inju		ime of	28c. Injury Work				w injury occurred	ony)	
on	th: Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		iy Year) Ir	ijury M		(? Yes 2 □ N	0				
<u> S</u>	Atter dea octor	ifica	3 ☐ Suicide 6 ☐ Could not	4 Z89. PIACE OF III	jury - At home, far	m, street, facto	ry, office		28f. Lo	ocation (Str	eet and Number or F	lural Route Nu	mber,
á	al or A s after il Dire	Certification:	4 Homicide	building, e	tc. (Specify)					ity or Town,	, State)		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying F (Check only one) 1 Medicel Exe	hysician: To the best miner: On the basis of and manner s	of examination and	, death occurre Vor investigation	d at the tim	e, date and pinion, death	place, and du occurred at t	ue to the car the time, da	use(s) and manner a te and place, and du	s stated. e to the cause	(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			2	9c. License	number		29	d. Date signed (Mor	th, Day, Year)	
			> Ill Min	n			P21	1313			12/7/07		
	2		30. Name and address of person who Kin Kue Wun,				Ave	. Che	stert	own,	MD. 216	20	
	Sta	te	31. Date liled (Month, Day, Year)	32 Regist	rar's Signature	1 4							
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	ded #26 phy., 1		nls, Pleas 19/07, Allegany C	e Type or Print in I	Black In	delible lnk.	. Ensure All	Copies A	re Legible.	00005
			1 - For State Registrar	State of Marytar	Cei	rtificate of	Death		g. No.	39960
	Physici	an	1. Decedent's Name (First, Middle,	1 . 1	1			2. Date of Death Month	Day Year	
	/Media	al	Ernest Fr	rederick Con	DIN	4b. City. Town. o	or Location of Death	11	4c. County of Dea	
	Examin	er	Garrett Cov	44.4	1 1400	a Oak	cland, m	de	Char	
	Funeral		0 - 1	Sex (7. Age (In yrs.	'last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,) 7 - 2 0 - 1	0.0	rthplace (State or Foreign country)
	Director		217-66-9493 Usual Residence of Decedent	51	Yrs.			7-20-1	956	wv
	ryland		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Bs-f e	Director	MD Allega	ny El.	lersl					1 2 Yes 2 □ No
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or ftems 23s or 28s-f ehow event, the Medical Examinar must be notified at	οir	100. Street and Number 10007 Humming	hind lane		10f. Zip Code 2 1 5 2 9		10	g. Citizen of What C USA	ountry ?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.		dispanic Origin? (Spec an, Mexican, Puerto R	city Yes or No-	14. Race - Am Bleck, Wh	
36	safter, or fte	by Fu	1 Never Married 2 Married	1 1 XYes 2 □ No		1 ☐ Yes 2 X No		icari, etc.)	Specify	
Ö	ture!		3 Widowed 4 Divorced 15. Decedent's	Year or Dates: 77 -	16a. Dece	dent's Usual Occup	pation	16	6b. Kind of Busines	hite s/industry
215	e. en "na	Completed	(Specify only highest (Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of working	9		
121	led wii tygien her th		12	-41	La	borer	40 84-1-1-1-1	(Fines Adiable Ad	Constru	ction
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or frems 23a or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	o Be	17. Father's Name (First, Middle, La Ernest Freder		Ħ		18. Mother's Name Barbara			
aryl	should and Men a marke umatic	To	19a. Informant's Name/Relationship			ng Address (Street				Zip Code) MD 2 1 5 2 9
Σ	and 2 ealth a n 27 to		Sandy K. Cork				ingbird			E-12-12-12-12-12-12-12-12-12-12-12-12-12-
lore	Pages 1 nent of He int: if iter		20a. Method of Disposition 1	Removal from State	cemetery, crer	sition (Name of matory or other plac	' I	11.0	0c. Location - City o	
Ë	artmer artmer ortant; injury b.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Euneral Service Lice		yndma	n Comet. Name and Addre	ery 11-2	0-07 H	tyndman,	PA
Ва	Departr Imports eny inj		1110004	MATTIME			Clarenc	rvey H.	. Lengke Hundman	r Funeral PA 15545
•	Physician /Medical Examiner		23a. Part 1. Enter the disease or co shock, or heart failure. Lest on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the deat by one cause on each line. a	th. Do not ent					Approximate Interval Between Onset and Death
	ed sit	iner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a conseq	quanca of):					
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760,	e be e) /sicien e buria			d.						
89	ntificat ng phy s as th	Medi	IF FEMALE:							
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of continuous 9 □ Unknown	eldeath 3	Ectopic pregnancy Other (specify)	y		23d. Date of di Month	elivery Day Year
ď.	s that ned by e deta	by Ph	Part II. Other significant conditions		sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires that been signed to should be det	ted t	Cirnh	75/5				1 ☐ Yes	2 □ No 3 □ F	Probably 4 Hunknown
Reco	nelawr hasbe ge 2 sh	Completed						24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of
tal	Physician: The la r this certificate has ral director, page 2	0	25. Was case referred to medical				26. Place of Death	1 Yes 2	DNo 1□Ye	s 2 No
Ž	nysici nis cer i direc	To B	examiner? 1 ☑ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	nt 3 DOA Oth				ecify)
0 0	ing Pi		27. Mann of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		8d. Describe how	v injury occurred	
isio	death death ctor: y the f	ficat	2 Accident investigat 3 Suicide 6 Could not determine	be gen Bless of Injury At h	ome, farm, str		Yes 2 No	8f. Location (Stre	eet and Number or F	Rural Route Number,
ρi	s after s after at Dire ed in b	Certification:	4 Homicide determine	building, etc. (Specil	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	owledge, death	occurred at the tir	me, date and place, ar	nd due to the cau	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	ithin 2	Medicai	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Mor	
	,		1 Jank	(runner		06	1801	1	vov. 1	7,2007
	10+		30. Name and address of person wh	o completed cause of death (Iter	m 23a) (Type,	Print)			,	
	MN		31. Date filed (Month, Day, Year)	Zejesky ung 32. Registrar's Signa	311 N	4-09 91	, Suitel	cake	and in	N 51520
	Sta Registr		NOV 1 9 700	7 A They istrar's Signa	Sacre	60				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year /Medical **JAMES** DIXON SR. 07 10 0804 Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1**☑** M 2□ F Director 69 212-38-6464 April 12, 1938 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 232 Shaw Street Funeral U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) meat cutter 12 grocery store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Dixon Naomi R. Hoover ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Patricia Ann Dixon wife 232 Shaw Street Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park November 13, 2007 Frostburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Due to (or as a contequence of): Iter /Medical Examiner Due to (Grae a concequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 HEURY Examine certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) detached the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ¥Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 **X**No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🖰 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 5 04205 10 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) nos Drue Cumber land 912 Seton Donaldson 3. Registrar's Signature State NOV 1 3 2007 Registrar

DHMH 17 Rev 1/2001

State Registrar

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nes

29b. Signature and the

30. Name and address of person

Date filed (Month, Day, Year)

NOV 1 4 2007

29c. License number

29d. Date signed (Month, Day, Year)

BEHOP Walsh Rd, Cumberland MD 21502

and manner stated.

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

925

M.D.

Box 68760. P.O. Division or Vital Records.

Baltimore, Maryland 21215-0036

Director: filled in by fo the Hu.
within 24 hours.
To the Funeral D'
'etely fille WIL 6+1

HOUR Certification: To 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 South Center Street WESTMinster, MD21157 State NOV 2 9 2007 Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GERTRUDE AULINE DMONDS /Medical 4b. City, Town, or Location of Death **Examiner** Facility Name (If not institution, give street and number 4c. County of Death 8. Date of Bilth (Month, Day, Year) April 1, 19 Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1 □ M 2 🔀 F Hours 31-36-3881 Director 1925 Brunswick Co. Usual Residence of Decedent 10c. City, Town or Location 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 ¥Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1216 Woodbourne 21239 LI SA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No þ Specify 3 Nidowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 8+h Housekeeping NUTSING Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Johnson ပ Nannie Fields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burston Daughter Woodbourne Ave. altimore MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State ittle Mt. Bapt. Ch. Con. 12-11-2007 4 Donation 5 □ Other (Specify) Blackstone, VA 21. Signature of Funeral Service Licensee CIC 22. Name and Address of Facility W. E. HAWKES SON FUNERAL HOME, INC. 504 East St. - BLACKSTONE, VA 2 Michael as Hawker 0448 BLACKSTONE, VA 23824 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute myo condial Physician robuble disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pertension Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Lath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No e Funeral Director: etely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062735 December 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

5601

MD

2. Registrar's Signature

parna Jonnal

13 2007

31. Date filed (Month, Day, Year)

Loch Raven Blvd, Baltimore, MD 21239

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Zel November 26 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c, County of Death Examiner Rida (arrol Kesville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 05 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 99 409-66-0996 AR 1908 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 710 Obrecht Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 H No Specify: White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J.C. Penney Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Ida Hawkins John Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Sycamore Lane Hanover, PA Jeanette Witt/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Carroll Cremation, Inc 11/28/2007 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 2PrittsAftinefally Home and Chapel, P.A. Westminster, MD 21157 412 Washington Road 23a. Int. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician End Deme disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed? To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ Ño Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 0 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 0005994 WIL completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 295

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name Prist, Middle Last #8/wchd/map/11-28-07 2. Date of Death 3. Time of Death Day **Physician** FRANCES M EASON VOV 25,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vicomico Lisbury Rehab + Nursing Ctr lisbi Sa 5. Social Security Number 7. Age (In yrs. fact birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8 Date of Birth 10003 - 0109 1057) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2□F 214-32-2154 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits YYes 2 □ No MD WICOMICO CO SALISBURY Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a or 2 iner must be n 200 CIVIC AVE 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify: þ Specify: BLACK 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) DCMESTIC LABORER HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RENNIE WEST ဥ MAZZIE PARKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EARL HANDY COUSTN 28223 ROCKAWALKIN RD SALISBURY MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of important: if it any injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 5 Other (Specify) 4 ☐ Donation 11-28-07 DELMAR DELAWARE 21 Signature of Emeral Service 22. Name and Address of Facility BENNIE SMITH FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part1. Env.; the dise shock, or mart failure , or complications that caused the bath. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** n consequence of): /Medical Due to (or 38 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Rug. consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autonsy 1∐ Yes 2 40 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 1 ☐ Yes 2 ☐ 1/0 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Perfifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) Mil sobins, am

State

Registrar

31. Date filed (Month, Day,

Year)

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Christophor	Erock

hristopher Frod			tment of Health and Mental Hyg <i>ificate of Death</i>	iene _{Reg.}	No. 2007	3997
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death	av Vear	Time of Death
ledical Exami	ner	Christopher Bryan Frock 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 2	4c. County of Death	0825 hrs
		Carroll Hospital Center	Westminster		Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 212-78-1720 1x M 2 F 47	Months Days Hours Min	3. Date of Birth(MM/DD/YYYY) 9. Birthp 1960 Foreign Count	100
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location		10	Od. Inside City Limits
Aaryiand 28a-f show	ō	MD Carroll W	estminster			Yes 2 XNo
Maryi or 28a-	Director	10e. Street and Number	10f. Zip Code 21158	10g	. Citizen of What Country USA	?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medical Examiner must be notified at once.		729 Stone Road 11. Marital Status 12. Was Decedent Ever in U.S		fy Yes or No-	14. Race - American	n Indian, Black,
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2121: thould be fill and Mental H is marked atic event,	ToB	Carl Franklin Frock, Jr 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	Brvan al Route Numb	er, City or Town, State, Z	ip Code)
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati		Maryann Frock/wife 20a. Method of Disposition 20b. Pic	729 Stone Road Westmin ace of Disposition (Name of cemetery, 11/29)	nster,	MD 21158 20c. Location - City or To	um Stoto
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'nijury or other traumatic event, the Medical.		1 XBurial 2 Cremation 3 Removal from State	ematory or other place) asant Valley Cemetery	72007	Pleasant Va	
Baltimo permit. Page: Department o Important:		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licer(see	Princes Application Home	and Ch		
Dep Der		John V- Marel	412 Washington Road	Westm	inster, MD	
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ted Junsit	Exa	events resulting in death) Last Due to (or as a consequence of): d.	:			
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Division of Vital Records, P.O. Box 68760, Roypital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director: After this certificate has been signed by the attending physician and eld filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	□ = · · · · · · · · · · · · · · · · · ·		23d. Date of delivery	
OX 6876 eath certificat eatherding ph	iciar	past 12 months? 4 Pregnant at time of deat	2 Fetal death 3 Ectopic pregnancy th 5 Other (Specify)	y	Month Day	/ Year
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Records, The law requir ficate has been si	ompleted		-	24a. Was an autopsy		osy findings available
Reco	omp	-		perform	ed? death?	2 No
Vital Rechysician: The this certificate	Be C	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 V	26.Place of Death (Check onl			
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OD C ending sath. or: Af the fun	ţį	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division To the Hospital or Attenti within 24 hours after death. To the Funeral Director: /	Certification:	Suicide Could not be	me, farm, street, factory, office building, etc. 28	if. Location (Str or Town, Sta	eet and Number or Rural te)	Route Number, City
O ospital hours		4 Homicide determined (Specify) 29a. Certifier A Continue Description To the head of surface and the surface of the surface o				
To the Ho within 24 I To the Fu	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge one) 2 Medical Examiner: On the basis of examination and and manner stated.				
MIL	Me	29b. Signature and title of certifier	29c. License number	1	29d. Date signed (Month	, Day, Year)
30		Carol Hallan	O.C.M.E.		November 25, 200 	7
		30. Name and address of person who completed cause of death (Item 2 Carol Allan, MD Assistant Medical Examiner 1	23a) 111 Penn Street, Baltimore, MD 21201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e			
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	Physici //Medic		1. Decedent's Name (First, Middle, Last) Sallie Virginia Fromm			2. Date of D Month Novemb	Day	Year 2007 22 MM
Sales of the sales	Examir Funeral		1 DM OFF	s. last birthday)	4b. City, Town, or Location Westmins If Under 1 Year If Under Months Days Hours	of Death ter 24 Hrs. 8. Date of B	4c. County o	
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	e Maryla 8a-f sho	Director	MD Carroll		minster			10d. Inside City Limits 1 ☐ Yes 2 🙀No
	th with the 23a or 2, ust be no	ral Dire	10e. Street and Number 86 Sunshine Way		10f. Zip Code 21157		10g. Citizen of Wi	-
9036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in UArmed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☑ No Specify:		o- 14. Race Black, Specify:	- American Indian, , White, etc. White
Maryland 21215-0036	d within 72 hegiene. grene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired) Homemaker	st of working	16b. Kind of Bus	iness/industry Home
yland	12 should be filed and Mental Hygris marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) John Henry Frederick Reth			er's Name <i>(First, Middle</i> Sallie Brit	cher	
	and 2 sho lealth and m 27 is ma her trauma		19a. Informant's Name/Relationship (Type. Print) Joan Carrigo/daughter	86 S	ng Address (Street and Number Sunshine Way	Westminste	c, MD 21	157
Baltimore,	Page nent c ant: If ury or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	oudon Pa	natory or other place) ark Cemetery	Date 11/26/2007	Baltimo	
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итан жес	B 85 A	Completed				24a. Was auto perfi 1 Yes	ppsy pri- prmed? de:	ere autopsy findings available or to completion of cause of ath?
VISION OF VII		Certification: To Be	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ER/Outpatient 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 I	No	idence 6 □Other how injury occurred	
2	ospital or hours after uneral Dire		29a. Certifier 1 Certifying Physician: To the best of my kno	owledge, death	Occurred at the time, date an	City or To	wn, State)	nor as stated
		Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	anon and/or inv	29c. License number		29d. Date signed (
7	MJL		30. Name and address of person who completed cause of death (Iten	m 23a) (Type, P	Print) DOOXS.	EMERG CALROL	11/22 DKP7	10 T 200 Memorial Ave CTR WESTMIN
	Stat Registra	~	31. Date filed (Month, Day, Year) Solution 32. Registrar's Signal NOV 2 6 2007		brest ,	CHECK	1/03/	(70,21)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month)

Lakshmi Vaidyanathan

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andyanothan

MD

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219

29c. License number

S. Washington St. Eastn, MD

29d. Date signed (Month, Day, Year)

NOVEMBER

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Helen Theresa Freese 0336 Mav. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico lisburg Salisburu Rehalo + Nursinoctr If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5/30/1924 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🕱 F 83 302-14-0004 Ohio Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Wicomico Director Maryland Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be It any injury or other traumatic event, the Medical Examiner must be It 8914 Executive Club Drive 21875 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Marta Aniela Ochel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul V. Freese/husband 8914 Executive Club Dr., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other pla Trinity Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/07 Waldorf, MD Gardens ature of Funeral Service Licenses 22 Name and Address of Facility Home Professional Association CFSP David 501 Snow Hill Rd., Salisbury, MD 21804 Udompso 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause preach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the SB attending esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2☐NO 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an certificate 1∐ Yes or Vital 2 🖳 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dil this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Year)

200

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dec 2, 2007 8:10pm Hebb Sarah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Living Center of Cumberland Allegany Cumberland 8. Date of Birth (Month, Day, Year) Apr 3, 1912 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 217-28-9421 95 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Cumberland 1 ☐ Yes 2 ☐ No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: Specify: 3 ₩ Widowed 4 Divorced "natural", white Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Effie Dawson Bealer Jessie Lee Bealer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 W. Third Street MD 21502 Cumberland Dorsey Hebb Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 12/6/2007 Mt. Tabor Cemetery MD Spring Gap 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA Signature of Funeral Service Acensee 108 Virginia Avenue: Cumberland, MD 21502 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro vancula **Physician** Azerchil /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. I signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) Injury 5 Pending within 24 hours arter co...
To the Funeral Director; Aft 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marine as stated. (Check only one) 2 Medical Examiner: To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gas Kent Ave. Comberland, MD 21502 An. D

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elizabeth Amelia Heinard November 2007 10:00 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10111 Ashburton Lane Bethesda Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 □ M 2 1 1 F Director 578-22-3399 86 District of Columbia July 30, 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Director 1 ☐Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10111 Ashburton Lane 20817 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marke other traumatic ၉ Edward Sweeney Mary Broderick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry E. Heinard - Daughter 25290 Pealiquor Road, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2007 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has l autopsy performed? Yes 2 No certificate 1∐ Yes or Attending Physician: funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number DOD 62 500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geeta Raja, M.D., 10215 Fernwood Road, Suite 100, Bethesda, Maryland 20817

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Bay)

egistrar's Signature

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** p^{M} Donald Eugene Hann November 26 2007 7:53 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Nov 16 1934 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days TX M 2 D F 218-32-9282 73 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2X No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Kirkhoff Road 21158 USA must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ž No Specify. White Specify: þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman/Driver Ferrell Gas Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Hann Estella Fridinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 223 Kirkoff Road Westminster, MD Mary J. Hann/wife 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/28 2007 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service bicensee Pritts Funeratione and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causejon each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dure to for as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Year 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 es 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause o death? perform 2 No PAME funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 Certification: To PIL 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation hours af er death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours at To the Funeral D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and address of person who complete

31. Date filled (Month, Day, Year)

KUZbersh

2007

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Westminster

21157

cause of death (Item 23a) (Type, Print)

CM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 24, 2007 10:33 p ^M Yong C. Hong November 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Aug. 15, 1941 Months Days Hours Min. Aug. 214-84-0151 66 China Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County MD Anne Arundel Arnold 1 TYes 217 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 USA 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify. Specify: Asian 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) Hair Fashion Owner/Operator/Hairstylist 12 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yoonmi H. Lee/Daughter 8429 Manuel Cia Pl. N.E. Albuquerque, NM 87122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Mem. Park 2007 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility Barranco & Sons, P.A. 495 Cov. Ritchie Hwy. Severna Park Funeral Home i (Su Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) a∐lJnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

Physician /Medical Examiner

Department of Health ar Important; If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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filed within 72 hours after death with Hygiene.

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Pages 1

Baltimore, Maryland 21215-0036

burial-trai the Jse for igned by the a be detached f page 2 should

that the death certificate be executed

Examiner Physician/Medical Completed by funeral director, Be Medical Certification: To the filled in by

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29b. Signature and title of certifi 31. Date filed (Month, Day, Year) State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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			1 - For State Registrar	State of Ma	ryland / Dep	artment of F			iene _{g. No.} 2 0 0 7	39981
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	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23e	eral	2740 Snow Hill	Road 12. Was Decedent B	Currie II C 12	21829	innerio Origina (C	Table Vac as No.	U.S.A.	oden ledine
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-1 show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 □ Yes 250 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Black, Whi	
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an	ould be Mental sarked o	To Be	Emil Zueger					Crissey		
Maryland	2 should be and Mental Is marked (19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street			City or Town, State,	Zip Code)
Z O	and 2 fealth m 27 her tra		William E. Heis	er (Son)		Public I			Hill, MD	21863
100	ages Int of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			osition (Name of matory or other place		Date 01/2007	20c. Location - City of	
altimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 ls any Injury or other trai		*4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Lices		Spence Ba	2. Name and Addres		01/2007	Snow Hill	, MD
Ã	Depa Depa Impo		Gwell.		S	hort Fune	ral Home	13 E Gro	ove St,Del	mar,DE 19940
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P.O. Box 68	Attending Physician: The law requires that the death certificate be executed redeath - death - death sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
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eco	e law requir has been si je 2 should I	Completed						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
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Division of Vital Records,	ding Phys th. : After this funeral di	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injung (Month, Day	t 2 ☐ ER/Outpatie / Year) 28b. Time of Injury	t 28c. Injun Work	at (? Yes 2 □ No	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)
Divisi	i Dife	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farm, st (Specify)			28f. Location (Str. City or Town	eet and Number or R , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifying Ph (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
1	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License		25	d. Date signed (Mon	th, Day, Year)
(my	-	Clyde E. Gal 30. Name and address of person who d	L > ms	ash (lase: OO:)	2006	3253		11-27-	07
	U		Clyde & 6	by Ta M.	ath (Item 23a) (Type,	erinti)	, MO 2.	1863		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 2 9 20	107 Section	's Signature	book				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12:40^a м **Physician** Thomas Leigh November 27, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 157M 2□ F Yrs March 6, 1925 Washington, DC 82 Director 579-20-8924 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County 28a-f shov notified at 1 ☐ Yes 2 🛣 No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ital Hygiene. Id other than "natural", or items 23a or : event, <u>the Medical Examiner must be r</u> USA 20815 8100 Connecticut Avenue, #221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Morris Item 27 is marked r other traumatic e B. Frank Joy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8100 Connecticut Avenue, #221, Chevy Chase, MD 20815 Frances H. Joy/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Nov. 30, Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final codiovasculas disea arteriosclesono hous **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? တ် Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Tery Record Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform certificate 2. No Division or Vital 25. Was case referred to filedical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Thatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 -, MIC 55410 inchesman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yeigenry Gruenan, 860001d George Lann Rd, Bellies da, min 20814, Suby 0+1

State Registrar 31. Date filed (Month, Day, Year)

HONA

32. Raistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:15 aM November 2007 Estelle Jordan Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13400 Dove Street Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs 1□M 2ĂF Months Hours Min. 83 Director 230-26-8668 Virginia July 28, 1924 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U.S.A. Funeral 13400 Dove Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Ş Q Specify: 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Jordan Annie Brown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Riviera Court, Silver Spring, Maryland 20904 Sheila Jones - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery crematory or other place)
Chapel Grove Baptist 1 ₭ Burial 2 Cremation 3 Removal from State 12/05/2007 Evington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service L -22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 6 weeks disease or condition resulting in death) Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner aftending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month signed by the all d be detached for 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 🗓 No 1□ Yes 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 No 3 □ DOA ဥ 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 2 ☐ Accident 24 hours after death e Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 😡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DC18561 November 28, 2007 10 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) David J. Perry, M.D., 110 Irving Street, NW, Washington, DC 31. Date filed (Manth) 32 Segistrar's Signature State fracti, Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 39984 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER TONY EDWARD WILKINS JOHNSON 2007 10:38 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠**M 2□F Yrs. Director 46 112-56-7538 1961 DISTRICT COLUMBIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 Yes 2 No MARYLAND HARFORD **ABERDEEN** the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1535B MITCHELL LANE 21001 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after I □Yes 2 □**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MOVING COMPANY DRIVER 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mental | Pages 1 end 2 should be import of Health and Mentatent: If Item 27 le marked jury or other traumatic ev ALTER WILKINS FAYE MCLEOD 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 HANOVER STREET, APT E, ABERDEEN, MARYLAND 21001 TYWANNA KING / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or once. 11/30/07 R.A. FERRIS & CO, INC WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. Scott- Coleman 552 LEWIS STREET, HAVRE DE GRACE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemotholax /Medical Due to (or as a consequence of) Examiner Cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetel death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes No. Certification: To 2 ER/Outpatient 3 DOA To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 □Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) D0064040

Registrar

State

Richal

31. Date filed (Month,

Wilkins- Johnson

5015. Union lue Have de Grace, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Régistrar's Signature

Tempel

Qay, Year)

			For State Registrar		State of	Maryland	-	artment of H tificate of L		and Me		ene g. No. 0	07	39985
b	Physici	an	Decedent's Name (First								2. Date of Death Month	Day	Year	3. Time of Death 2:25 P _M
P.	/Medic	al	Virginia B 4a. Facility Neme (If not i			ber)		4b. City, Town, or	Location of	of Death	Nov	25 4c. County	2007 y of Death	
	Examin	er	3 63rd St.,					Ocean C				Wo	rcest	er
	Funeral Director		5. Social Security Number 213–44–8049		(]M 2□ y F	'. Age (In yrs. Ias 96	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, June 3,		Cour	lece (State or Foreign try) MD
	and w		Usual Residence of Dece 10a. State 10b.	. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
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	ath wi	raiD	3 63rd St.,					218				US		
920	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f ahow imatic event, the Medical Examinar manal be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 3 November 4	2 Married	12. Was Deced Armed For 1 Tyes If Yes, Give Year or Da	•	'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🕱 No	ispanic Ori in, Mexicar Specify:	n, Puerto R	ify Yes or No- lican, etc.)	Bla	ce - Americ ick, White, fy: Whi	etc.
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timor	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe ODCS.		20a. Method of Disposition 1 Burial 2 ACre 4 Donation 5	emation 3 \square P Other (Specify)		Cen	netery, crem natory Delma	natory or other place of irva		11/26	/2007	Delma		
Bai	Departiment of the poor of the		21. Signature of Euroral	uCDH1) plsst	1	1 1	Name and Address Ewis N. 1 618 West	Watso Rd	n Fun Sali	sbury.	MD 218	01	
	Pnysician /Medical Examiner		23a. Part1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death)		10	used the death. Inc. Office of the death. Office of the death.	1 A	ge III	lg, such as Naf	yuul yuul	Cours	st. U		Approximate Interval Between Onset and Death
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.O. Box 6	that the death certificate be executed ted by the attending physicien and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	ths?	1□Live bi	ome of pregnand nth 2 ☐ Fetal d ant at time of dea wn	eath 3	Ectopic pregnancy Other (specify)				1	ate of delive	ery Day Year
rds, P.	The law requires that the tee been signed by the page 2 should be detached.	by	Part II. Other significant	conditions co	ntributing to de	ath but not resulti	ing in the u	nderlying cause give	en in Part I		23e. Did tob 1 ☐ Ye		uribute to t	he cause of death?
Vital Records,		Completed									24a. Was ar autopsy perform 1 Yes 2	1 0	Were auto prior to co death? 1 \(\subseteq Yes	psy findings available impletion of cause of 2 ID No
Vita V	Attending Physician: The r death. ector: After this certificate hiby the funeral director, page	Be	25. Was case referred to examiner?	-	Hospital:		Tallens.	Oth	00		(Check only one			
	Phys r this oral dir	1: To	1 Yes 2 No	4.	28a. Date o	f Injury 2	R/Outpatien 8b. Time of	28c. Injun	y at	rsing Hom	8d. Describe ho	nce 6 ⊡Ot w injury occu		(y)
on	Attending Ph or death. ector: After th by the funeral	atior	1 DNatural 5 [2 ☐ Accident	Pending investigation	(Monti	n, Day Year)	Injury	M 1 🗆	k? Yes 2 □	No				
Division of		Certification;	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined		of Injury - At hom g, etc. (Specify)	e, farm, str	eet, factory, office		2	8f. Location (Str City or Town	reet and Num , State)	ber or Rura	al Route Number,
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	To the within comple	×	29b. Signature and title	M (200,1	WP		29c. Liesns	-3C	576	4	ed. Date sign	27/	yay, year)
/	HIP		30. Name and osl o	Gra	er, n	of death (Item 2	241	7 Oceu	Gua	feur	ry Suit	esA	06	an City, Md
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			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 7 3 9 9 8	36
	D.	Ш	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De	eath
	Physici /Medio		Mildred G. Kuehn December 6, 2007 2:57	A_{\bullet}^{M}
	Examir			
			309 South Parke St. Apt. B-35 Aberdeen Harford	
	Funeral Director		5. Social Security Number 219-01-2752 7. Age (In yrs. last birthday) 89 Yrs. 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 1 Days Hours Min. 3/30/1918 9. Birthplace (State or F Country) Maryland	oreign
			Usual Residence of Decedent 3/30/1918 MaryLand	
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City I	Limits
	a-f s	Director	MD Harford Aberdeen 10XYes 2	□No
	iff the	Jire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ath w	rail	309 South Parke St. Apt. B-35 21001 U.S.A.	
	ter de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
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yla	should build Ment	70	Irvin James Lambdin Carrie Chandler	
Maryland	2 0 0 0		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Sloan, Sr. (son-in-law) 966 VanBuren St., Havre de Grace, MD 21078	
	1 and Health em 27			
altimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Ξ̈́	permit. Page Department o Importent: If eny injury or ence.		'4 Donation 5 Other (Specify) Cedar Hill Cemetery 12/10/07 Baltimore, Maryland	
Ba	permit. Departr Importe eny inje		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A.	
			23a. Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate	
by			Interval Betwee Onset and Dea	
	Fnysician /Medical		disease or condition a	-
P	Examiner		Due to (or as a consequence of)	
		Je.	Sequentially list conditions D	
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9	entifica ling pl e as t	Med	IF FEMALE:	
Вох	w requires that the death certifics been signed by the attending ph should be detached for use as the	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Yea	ır
P.0.	he de the s	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown	
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Sp.	uires n sign ld be	d by	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Winki	
00	w req	lete	24a. Was an 24b. Were autopsy findings ava	ilabla
Vital Records,	The law te has age 2 s	Completed	autopsy prior to completion of caus performed?	e of
g	ilcien: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Death (Check only/one)	
<u></u>	Attending Physicien: The rideath, ector: After this certificate his by the funeral director, page	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 N esidence 6 Other (Specify)	
0	ding Ph h. After th funeral		27. Many r of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?	
Division of	endir sath. or: Al he fu	Certification;	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
Ë	l or Attence after death Director: in by the	TE I	3 Suicide 6 Coyld not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	urs al			
	Hos 24 ho Fune stely f.	edical	29a. Certifler (Check only one) (Check only on	
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	४ नं ६ ⊣		1444 Gim MD DULLY 12/6/2	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	1,3-		High Lim 319 S. Whom AVE 1176 MB 4078	
	Stat	e	31. Date filed (Month, Day, Year) 32./ registrar's Signature	
H,	Registra	ar	DEC 13 2007 Decre & Sparker	

DHMH 17 Rev 1/2001

	1 - For State Registrar		ryland / Dep <i>Ce</i>	rtificate of			eg. No. 200	3998						
ician	Decedent's Name (First, Middle, L	ast) CAROL		KELLY		2. Date of Deatl Month	h Day Yea							
dical niner	4a. Facility Name (If not institution, gi	ive street and number)		4b. City, Town,	or Location of Dea	ath	4c. County of D							
adages .	WMHS-BRADDOCK (5. Social Security Number 6.		e (In yrs. last birthday	CUMBERL		s. 8. Date of Birth	ALLEGAN	IY Birthplace (State or Foreig						
al or	218-70-2004	1□ M 2 X F	60 Yrs.	Months Days			Year)	Country) MARYLAND						
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	r Location 10d. Inside City										
ş	MD ALLE	GANY	CUMBER	LAND				1 MYYes 2 □ N						
once. To Be Completed by Funeral Director		STREET		10f. Zip Code 10g. Citizen of What Country? 21502 U.S.A.										
Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of	Hispanic Origin?	Specify Yes or No- erto Rican, etc.)		merican Indian,						
by Fui		Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 X No		eno Hican, etc.)	0	vhite, etc. WHITE						
Completed	15. Decedent's E (Specify only highest g	Education trade completed)	16a. Dece (Give	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of Busine	ess/Industry						
E D	Elementary/Secondary (0-12)	College (1-4or 5	+)	TECH & CERT		I .	NURSING	HOME						
Be	17. Father's Name (First, Middle, Las	,				ame (First, Middle, N NE SMARR	Maiden Surname)							
2	19a. Informant's Name/Relationship					Rural Route Number,		te, Zip Code) ID, MD 21502						
	20a. Method of Disposition		20b. Place of Disp	osition (Name of	1		20c. Location - City							
	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		REST LAW	ematory or other pla N MEML • GA		/21/2007	LAVALE	E, MD						
ë	21. Signature of Funeral Service Lice	ensée		22. Name and Addr	ess of Facility	L HOME, P.	λ							
티	Hered 91.	CARCHUR	CSV	202_GRE	ENE_STRE	ET, CUMBEI	RLAND, MD							
	23a. Part1. Enter the Lease, or conshock, or heart failure. List only	mpli tions that caused by one cause on each lin	e.					Approximate Interval Between Onset and Death						
n al	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	PA70C/ a consequence of):	ELLUL.	AR C	ARCIN	OMA	MONT						
r	Sequentially list conditions,	b												
xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	. Consequence of.											
ш		Due to (or as	a consequence of):											
lical		d												
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery Month Day										
by Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause gi	iven in Part I.			re to the cause of death?						
- 1	1					1 Ye	es 2 No 3	, , , , , ,						
) sed			- M				ned? deati	e autopsy findings availa to completion of cause h?						
ompleted				performed? death? 1 Yes 2 No 1 Yes 2 No										
Be Completed						examiner?								
To Be	25. Was case referred to medical examiner? 1 Yes 2 No	I ⊿ Inpatte		THE SELECTION	her: 4 \sum Nursing	Home 5 ☐ Reside	ence 6 Dother (5							
To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28a. Date of Inju- (Month, Day	y 28b. Time	of 28c. Inju	her: 4 Nursing ury at ork?	Home 5 ☐ Reside								
To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28a. Date of Injur (Month, Day on be 28e. Place of Injur	28b. Time Injury	of 28c. Inju	her: 4 Nursing ury at ork? Yes 2 No	Home 5 Reside	ence 6 Other (Sow injury occurred							
Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not determine	28a. Place of injunded description on be description 28e. Place of injunded description of the best description on the basis of aminer: On the basis of	y Year) 28b. Time Injury Injury - At home, farm, so. (Specify) of my knowledge, dea examination and/or i	of 28c. Inju Wc M 1 [treet, factory, office	her: 4 Nursing ury at ork? Yes 2 No	Home 5 Reside 28d. Describe ho 28f. Location (Ste. City or Town)	ence 6 Other (5 ow injury occurred reet and Number of 1, State)	Specify) r Rural Route Number, er as stated.						
To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not determine	28a. Date of Injur (Month, Day be d 28e. Place of injur building, etc.	y Year) 28b. Time Injury Injury - At home, farm, so. (Specify) of my knowledge, dea examination and/or i	of 28c. Inj. Wc M 1 [2 treet, factory, office ath occurred at the to nivestigation, in my	her: 4 Nursing ury at ork? Yes 2 No	Anne 5 Reside 28d. Describe ho 28f. Location (Str. City or Town) ce, and due to the cacurred at the time, do	ence 6 Other (5 ow injury occurred reet and Number of 1, State)	Specify) r Rural Route Number, r as stated. due to the cause(s)						

7165 State

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Shiv Khanna 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

0054004

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39989 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200710:00P M Sadie E. Kidwell November 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehab Worcester Berlin 5. Social Security Number 8. Date of Birth May 16, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) New York 1 □ M 2 🔀 F Months Days Hours 217-18-2402 87 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10229 Keyser Point Road 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Hotel

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Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Kidwell, Sadie

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

þ

Completed

Funeral

Physician /Medical Examiner

by Physician/Medical

Be Completed

Medical Certification: To

within 24 hours after death.

To the Funeral Director: /

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Be (17. Father's Name (First, Middle, Last,)		18. Mother's Nam	ne (First, Middle, Maid	len Surname)			
To E	Unknown			Unknown					
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Stree	t and Number or Ru	ral Route Number, Cit	y or Town, State,	Zip Code)		
	Bette Utley		86 Seafarer L	ane, Ocea	an Pines, N	Maryland	21811		
	20a. Method of Disposition	20b. F	Place of Disposition (Name of cemetery, crematory or other place Henlopen Cre	ace)		Location - City or	Town, State		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)			9/2007 Fra	nkford,	DE		
	21. Signature of Funeral Service Licer	isee `	22. Name and Addr	ess of Facility The	e Burbage	Funeral Home			
	- feath for	mall			, Berlin,				
2	23a f art1. Enter the disease, or com shock, or a rt fellow. List only	plications that caused the death one cause on e. ch line.	h. Do not enter the mode of dy	ing, such as cardiac	or respiratory arrest,		Approximate Interval Between		
	Immediate Cause (Final disease or condition resulting in death)	e	Onset and Death						
	resulting in death)	Due to (or as a conseq	uence of):	00.000					
Ŀ	Sequentially list conditions,	b							
iner	cause. Enter Underlying	Due to for as a conseq							
аш	Cause (Disease or injury that initiated events resulting in death) Last	c							
Ě	resulting in death) Last	Due to (or as a consequent	uence of):						
ica		⊾d							
Med	IF FEMALE:		-						
Jue	23b. Was decedent pregnant	23d. Date of de							
Completed by Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Month	Day Year						
든	Part II. Other significant conditions of		o the cause of death?						
þ	rait ii. Other significant conditions o	onabuling to death but not rest	ulang in the underlying cause gi	ven in Fait i.			_		
ted					I ∐ Yes	2 NO 3 P	3 ☐ Probably ★ Unknown		
p e					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
NO.					performed 1□ Yes	? I death?			
Be	25. Was case referred to medical examiner?			26. Place of Deat	th (Check only one)				
0	1 Yes 2 1 Ho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Ot	her: Nursing Ho	ome 5 Residence	6 □Other (Spe	ecify)		
Ë	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Inju	iry at	28d. Describe how in		*		
atio	2 ☐ Accident investigation	1		Yes 2 □ No					
ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he	ome, farm, street, factory, office		28f. Location (Street City or Town, St	and Number or R	ural Route Number,		
Se L		building, etc. (opcon)	,,		City of Town, St	ate)			
Medical Certification: T	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wiedge, death occurred at the	ime, date and place	, and due to the cause	e(s) and manner a	s stated.		
edi	one)	and manner stated.	mon and/or investigation, it my	opinon, death occu	ired at the time, date	and place, and du	e to the cause(s)		
Σ	29b. Signature and title of certifier			se number		Date signed (Mon.			
	11/1/ Mu	nos	> 10	18269	10	12960	17		
	30. Name and address of person who	completed cause of death (Item	1 23a) (Type, Print)	1.	-	110			
_/	Viduolas Poros	lulin, und 12	209 Coastel 1	glan /E	urch Fer	ed, 16	19944		
е	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	9		1			
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DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #19b per fh, 11/30/07,eb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Amos C. King November 27, 2007 2310 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6496 George Riggin Road Westover Somerset If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral 1**∕2 M 2 □ F Yrs Director 578-26-4238 10/05/1910 North Dakota Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6496 George Riggin Road 21371 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 other than "naturel", or 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 10 none Minister Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ent: If item 27 is marked o Harry Lee King Rosa Lee Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6496 George Riggin Road, Westover, MD 21871 Miriam King-Dagen/Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit, Page Department of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Holly Grove Mennonite 12/02/2007 Westover, MD Signature of Funeral Service Vicensee 22. Name and Address of Facility Hinman Funeral Home 23. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21253 Approximate Interval Between Onset and Death Princess Anne, MD Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disp to for as a ponsequence of Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Tes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 To the Hospitel

> State Registrar

within 24 hours a To the Funerel C

Medical

VIJAY 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier



🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 48098

29d. Date signed (Month, Day, Year)

HALLHIGHWAY CRISFIELD, MD 21817

29/2007

2H-011 State

31. Date filed (Month, Day, Year)

J

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South !

29c. License number

0005696

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walter KRAUSE Glenn 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month. Dav. Year) **Funeral** Days Hours 214-34-1567 1 M M 2 □ F Director 24,1935 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 East Oak Ridge Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tyes 2 No 1957
If Yes, Give
Year or Dates: 1959 1 ☐ Never Married 2 ★ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) gear cutter truck manufacturer permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Krause Florence Amelia Bach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Krause - wife 406 East Oak Ridge Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State December 4 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myo cardial Physician 1 HOUR disease or condition resulting in death) /Medical Due g (or as a consequence of): Examiner ar dear 1 HOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HY PERTENSION The law requires that the death certificate be executed aftending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical MENUN IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO D46561 12-1-2007 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) SH 5+1 20 BOONSBOW MD 21713 DADIR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

for Stata Registrar	
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			Registrar					Cei	unca	ie or i	Jeani			Reg. No)			
	Physic			e (First, Middle, La: Eleanor L									2. Date of D Month	Da	•	Year	3. Time of Dea	ith M
	/Medi Examir		4a. Facility Name (I	If not institution, giv	e street and nu	ımber)			4b. City	, Town, or	Location	of Death	Decemb		200 County o		7:35 P.	
			St. Cath	herine's	Nursino	r Hon	ne			mmits						derio	~1e	
	Funeral		5. Social Security N	lumber 6. S	ex		(In yrs. last birti	nday)		r 1 Year	If Under		8. Date of Bi	rth	-		ace (State or For	reign
	Director		220-28-93	106	□M 2Å F		73	rs.	MONITOR	Days	Hours	Min.	(Month, D March	25,	1934		gland	
	and *		Usual Residence of 10a. State	f Decedent 10b. County			10c. City, Town	orlo	ration							10	d Inside Oh 11	
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	death ms 2	Funeral	11. Marital Status	Pelmers	12. Was Dec	edent Ev	ver in U.S.	13. W	/as Dece	dent of Hi	217.		ecify Yes or No Rican, etc.)	0-	U.S.		n Indian	
စ	after or Ite	Fur	1 Never Marri	ied 2 Married	Armed Fo	2X No							Rican, etc.)			White, e	tc.	
9	rel',	dby	3 X Widowed	4 Divorced	If Yes, Gir Year or D	ve Dates:		1	☐ Yes	2X1 No	Specify:				Specify:	Wł	nite	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or Items 23e or 28a-1 show metic event, the Mudical Evertiner must be notified at	Completed	(Spec	15. Decedent's Ed	ducation ide completed)		16a. I	Decede Give k	ent's Usu	al Occupa ork done d se retired	ition Juring mos	t of worki	ng	16b. K	ind of Busi	ness/Indi	ıstry	
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Baltimore,	Pag nent ent: I			Cremation 3 ☐ 5 ☐ Other (Specify		State	Smiths					Dec.		Smi	thsbu	ra.N	id.	
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п	207 = 9		Jak	V/2)	Jauis .	Mo	1414						Home S.		sburg	,Md.	21783	
			23a Part 1. Enter the shock, or hear	he disease, or comp rt failure. List only	olications that cone cause on e	caused the	e death. Do no	t ente	r the mod	le of dying	, such as	cardiac o	r respiratory a	rrest,		í	Approximate nterval Between	1
	Physician		Immediate Cause (disease or condition	Final n	En	15	Tase	- (au	RE	die	12					Onset and Death	
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מ	e law has b	Completed											24a. Was autor	osy	pric	or to comp	y findings availabletion of cause	ible of
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-	sicien: The law s certificate has b irector, page 2 s	Be	25. Was case referre		Hospital:	_				-		of Death	(Check only o	ne)				
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2	or Attend after death Director: ,	ifica	3 Suicide	6 Could not be determined	28e. Place	of Injury	- At home, farm	n, stree					8f. Location (5	Street and	d Number o	or Rural I	Route Number.	
5	s afte	Certification:	4 Homicide	40,01111102	buildir	ng, etc. (Specify)		,,	,			City or Tov	vn, State)			10010 110111001,	
			29a. Certifier (Check only	Certifying Phy	sician: To the	best of n	ny knowledge, d	death o	ccurred	at the time	, date and	place, a	nd due to the	cause(s)	and manne	er as stat	ed.	
:	the H in 24 the Fi plete	edical	one)	2 Medical Exami	and mann	ISIS OF BX	amination and/	or inve	stigation,	in my opi	nion, deat	h occurre	d at the time,	date and	place, and	due to th	ne cause(s)	
ı	Vith Com	Σ	29b. Signature and t	itle of certifier			/)	290	. License	number	1,40	37	29d. Date	signed (A	Month, Da	y, Year)	
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	1		30. Name and addre	ss of person who co	ompleted cause	e of deat	h (Item 23a) (Ty	pe, Fr	int)	1	21-	123	(De)7	Me	cina	57	reel	
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			For State	State of Mary		partment of F <i>ertificate of</i>		ind Me	ntal Hy	giene		
r		- 4	Registrar 1. Decedent's Name (First, Middle, Last)			erinicale or	Dealli	2	Date of Dea	Reg. No.	200	7 2 0 0 0 1
i de	Physici /Medio		Robert Emmett	Lenihan					Month ovember	Day	2007 Year	10:38 p _M
-	Examir	er	4a. Facility Name (If not institution, give s	freet and number)		4b. City, Town, o	r Location of	f Death		4c.	County of Dear	th
	A Section 1	÷	46 Shaw Avenue	7 4 //			Silver				Montg	
	Funeral Director		504-10-0908	M 2□F	n yrs. last birthd Yrs	Months Days	Hours	Min.	Date of Birt (Month, Day ecember	y, Year)	Co	thplace (State or Foreign ountry) ontana
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Oc. Cify, Town or	Location						10d. Inside City Limits
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	r 28a	Director	10e. Street and Number			10f. Zip Code	CI OPIL	6		10g. Citiz	zen of What Co	Lountry?
	th wit 23a o Ist be		46 Shaw Avenue				20904				U.S.A	
	ems er mu	Funeral		Was Decedent Eve Armed Forces?	r in U.S. 1	Was Decedent of H If Yes, specify Cuba		in? (Specif	y Yes or No-	. 1	14. Race - Ame Black, Whit	erican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No	WII	1 ☐ Yes 2 ☒ No	Specify:	,	,		Specify:	White
у О	72 ho natur dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. De	cedent's Usual Occup ive kind of work done	ation	of working		16b. Kir	nd of Business	/Industry
7	/ithin ne. han " e Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	\\fif	e. DO NOT use retired	d) -	or working				_
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auc	d be f ental l	Be c									Surriame)	
2	should bd Me mark matic	욘	Frank Lenihan 19a. Informant's Name/Relationship (Typ	e. Print)	19b. M	ailing Address (Street			Wonder		Town State	Zin Code)
S	nd 2 suith ar		Ayeliffe Lenihan -	,		Shaw Avenue,				, , ,	, , .	EID OOGO)
ē,	s 1 ar	3	20a. Method of Disposition	-	20b. Place of Di	sposition (Name of crematory or other place		Date			cation - City or	Town, State
Ë	Page int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Spegity)	emoval from State		oln Cremator	i i	11/30/	2007	Bren	twood, M	aryland
Baltimore,	permit. Departn Importa any inju	ļ	21. Signature of Funer I Servi) Loense			22. Name and Addre	i Funer	al Hom				
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Box .	certi iding se a	Physician/Me	in the past 12 months?	c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/			2	3d. Date of del	livery Day Year
Д О	at the ded by the a	Phy	9 Unknown									
	w requires that been signed to should be deta	by	Part II. Other significant conditions conf	g to death but h	ot resulting in the	e undenying cause giv	en in Parti,		23e. Did to			o the cause of death? robably 4 □Unknown
Vital Hecords,	sician: The law requires that the death certificate has been signed by the atter irector, page 2 should be detached for u	Completed								sy rmed?	death?	utopsy findings available completion of cause of
<u>ra</u>	(0 17	Φ	25. Was case referred to medical				26. Place o	of Death C	1⊡ Yes heck onl∈ o	2k No	1 ☐ Yes	2 □ No
	Physician: this certificaral director, p	70 B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient	2 ER/Outpat	tient 3 DOA Oth				-	☐Other (Spe	cify)
n or	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time				. Describe h			
200	tendi leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1□	Yes 2□N	lo				
Division	i Pife	Certification:	4 Homicide determined	28e. Place of injury building, etc. (5		street, factory, office		28f.	Location (S City or Tow	Street and n, State)	l Number or Ru	ural Route Number,
	Hos Fun Fun sely	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physi 2 ☐ Medical Examin	cian: To the best of mer: On the basis of exand manner stated	amination and/o	eath occurred at the tir r investigation, in my c	ne, date and ppinion, death	place, and h occurred	due to the at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	70 0		29c. License	e number		:	29d. Date	signed (Mont	th, Day, Year)
	16		1 Tul No	Sul is		D11	441			Nov	ember 28	, 2007
1	13	Ì	30. Name and address of person who cor	npleted cause of death	(Item 23a) (Typ	e, Print)						
			3301 New Mexico Avenu	e, Suite 348,	Washingt	con, NW, DC 2	0016					
	Sta Registr		31. Date filed (Mort 19 2 200	32. registrar's	Signature	horse						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** FRANCIS LYNCH 07 1135 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 24 Hrs. (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days Months Hours Min. December 13, 1921 85 Maryland 219-14-5307 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Mount Savage 1 ☐ Yes 2 No Allegany Director Maryland 10e. Street and Number 16217 Callah Hill Road 10f. Zip Code 10g. Citizen of What Country? 21545-U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ∠ 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Be Completed by Specify: White 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aintance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Broderick Michael H. Lynch P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvland 21532-19a. Informant's Name/Relationship (Type. Print) Mary M. Broadwater Daughter 10016 Piney Mountain Rd Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Maryland St Patrick's Cemetery Mt Savage 4 □ Donation 5 □ Other (Specify) 120107 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dAY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed CARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 DOA

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and burial-trar physician the the signed by the page 2 should certificate has been funeral director, After this nin 24 hours after death the Funeral Director:

The law requires that the death certificate be executed

Physician:

or Attending

Hospital

0

Division or Vital Records, P.O. Box 68760

1 Tyes 2 No

3 Suicide

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 BROADINA

Mary and 21532

Registrar

filled in by

completely

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within 7

Certification: To

Medical

31. Date filed (Month, Day, Year)

SATURNINA

1 9 2007 NOA

State of Maryland / Department of Health and Mental Hygien [] 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Yeer Hyman E. Lavender 9:40 A M NOVEMBER 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1⊠M 2□F Months Days Hours Min. 90 124-14-2615 Yrs. Director July 29,1917 New York Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 17 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD Anne Arundel Severna Park Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 W. McKinsey Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW] Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene.
I Hygiene. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White WW II 1 Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked other Be Leo Lavender Rose Chall ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any injury or other tra once. Margo Woodard/Daughter Severna Park, MD 21146 401 Grist Mill Crossing 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State v. 26, 2007 1 Burial 2 □ Cremation 3 □ Remova From State MD Veterans Cemetery Crownsville, MD ¹ 4 □ Donation 5 © Other (Specify) 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service License P.A. Severna Park Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Severna Park, MD 21146 Onset and Death Immediate Cause (Final disease of condition **Physician** disease or condition resulting in death) ADVANCED DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death ed by the at detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MEART FAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? PIBRILL ATIO 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. 26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6 V the (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending s after dec. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a Hospitai To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai To tha Fun completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 21, 2007 D57531 on who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Hwy Suite 204 Millersville MD 31. Date filed (Month, Day, Year) State NOV 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Burnice Lee Landon /Medical December 2007 12:35 p.^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5312 Suburban Drive Dorchester Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 □ F Director 214-60-7658 54 Apr. 10, 1953 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov items 23a or 28a-f sh ner must be notified Dorchester Director Cambridge 1 ☐ Yes 2 No and 2 should be filed within 72 hours after death with the I ealth and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5312 Suburban Drive 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, "natural", or items edical Examiner n Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>م</u> Specify: white 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Deparment of Health and Mental Hygiene. Impor ant: If item 27 Is marked other than any Injury or other traumatic event, the Monce. carpenter home builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burnice Lee Landon ဥ Gladys Willev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Ellis daughter 5712 Church Home Road, Rhodesdale, MD 21659 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Salisbury Crematory 12/3/07 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SQUAMOUS Cell Carcinona 6 yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number

State Registrar

DEC 03 DHMH 17 Rev 1/2001

31. Date filed Month, Day, Year)

Imothe

30. Name and address of person who completed cause of death (Item 2)a) (Type, Print)

ierek

32. Registrar's Signature

MO

29d. Date signed (Month, Day, Year) 12-03-2007

Preston MD 21655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December Nettie Louise Moxley 5° 2007° ar 8:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 19 19 27 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🛛 F 80 214-28-0199 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Maryland Frederick Frederick 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 East Fourth Street 21701 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Who lf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond McDonough Daisy Haines 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
39 East 4th Street, Frederick, MD 21701 19a. Informant's Name/Relationship (Type. Print) Mr. Ralph W. Moxley, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Providence Cemetery Dec. 8, 2007 Kemptown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaryre of Funeral Service Licentee Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementio Yeavs Fire to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2□ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 □ Yes 2□ No 1□ Yes 2□ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 100 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner The law requires that the death certificate be executed

Department of Important: If any injury or once.

Funeral

Director

show r 28a-f shov notified at

ral", or items 23a or Examiner must be

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite Lry or other traumatic event, the Medical Examines

Baltimore, Maryland 21215-0036

with the Maryland

death v

burial-trai the as attending p ed by the a director, funeral

Certification: after death. filled in by

Medical

29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760%

Physician:

Hospital or Attending

After 1

24 hours a Funeral I

within 2

3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Johnson Dr. Frederick

29b. Signature and title of certifier

D0060417

29d. Date signed (Month, Day, Year) December 6, 2007

21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen ihamas C

31. Date filed (Month, Day, Year) DEC 13

and manner stated

State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Madero Mary Louise /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany 308 Furnace Street Cumberland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 □ F ΜD Sep 9, 1920 Director 219-90-7924 87 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Cumberland MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 308 Furnace Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: ģ 3 ☑ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merrill T. Foster Sadie L. Miles Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cumberland 310 Furnace Street MD 21502 daughter Joan Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/7/2007 MD Cresaptown 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland. MD 21502 23a. 11. Inter the disease, or corplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, socy or heart failure. List a yone cause on each line. Approximate Interval Between Onset and Death WITH METATASIS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list or dilices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 2∃No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director:

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINUA MACROSS, MP 9/2 STRN PRUE COMPENIANA, MD 2130 V 01/2

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Occemben 7,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 4:52 P M Willie Mae Jackson Mobley 20. /Medical Nov. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F Days Director 93 579-20-1369 13. 1914North Carolina Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shov ner must be notified at 1 ☑ Yes 2 ☐ No Director MD College Park Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 2 should be filed within 72 hours after death of and Mental Hygiene. Is marked other than "natural", or items 23 Funeral 8709 34th Ave. U.S. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black White etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 ₩ Widowed 4 Divorced American Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Officer Federal Government 17. Father's Name (First, Middle, Last) Unk. 18. Mother's Name (First, Middle, Maiden Surname) Unk. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8709 34th Ave., College Park, MD 20740 Lori Anne Taylor / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington_National Dec. 10, 2007 Arlington, VA 21. Signature of Faneral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Mon 7400 Georgia Ave., N.W. Washington, D.C. 20012 zsser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardine 122 10 /Medical Due to (or as a consequence of): Examiner min Dovolemic Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner r as a consequence of) requires that the death certificate be executed min. GI burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Briknown Chronic Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate | HTN 1□ Yes Division or Vital 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medical Direct 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2

18101 Pronce

egistrar's Signature

Ph.lip Dr Olnes 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)